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August 17, 2012

SCDuE Demonstration RFI
c/o Nathaniel Patterson – 7th floor
S.C. Dept. of Health & Human Services
P.O. Box 8206
Columbia, SC 29202
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Dear Mr. Patterson:

On behalf of Select Health of South Carolina, Inc., it is our pleasure to submit our response to the SCDuE Demonstration Request for Information. We have the same mission as the South Carolina Department of Health and Human Services --provide the best health care for consumers for the least cost to South Carolina's citizens.

In our response, we share with you:

- Proven programs and care teams designed to drive efficient and high quality care
- An engaged and comprehensive provider network interested in building patient-centered medical homes
- Established infrastructure and 16-years of experience supporting South Carolina members
- Integrated information technology systems with data storage and sharing capabilities
- Experience creating financial alignment between care partners

Thank you for giving us the opportunity to submit this request. We look forward to working with you on this demonstration.

Sincerely,

Mike Jernigan
President and Chief Executive Officer

Dual Demonstration RFI Response

PART 1 - TELL US ABOUT YOURSELF (RESPONDER/RESPONDING ORGANIZATION):

A. Is your organization interested in the opportunity to serve as a Coordinated and Integrated Care Organization (CICO) under the South Carolina Dual Eligible (SCDuE) Demonstration?

Select Health of South Carolina, Inc. (Select Health), a wholly owned subsidiary of AmeriHealth Mercy Health Plan, provides Medicaid managed care services to 235,000 TANF, SSI and CHIP members in South Carolina and will begin serving Medicare, D-SNP members as of January, 2013. Select Health has earned an Excellent Accreditation status from NCQA and is one of the first six plans in the nation to be awarded NCQA's Multicultural Healthcare Distinction. We have the same mission as the South Carolina Department of Health and Human Services (SC DHHS)--provide the best health care for consumers for the least cost to South Caroline's citizens. **Select Health is pleased to submit our response to the SCDuE Demonstration RFI and would be pleased to serve as a Coordinated and Integrated Care Organization (CICO).**

The Proposal to the Center for Medicare and Medicaid Innovation indicated that SC DHHS would like to create an integrated and coordinated system of care for individuals who are dually eligible and could benefit from a person-centered, multidisciplinary care team, supported by a comprehensive provider network and data sharing that creates a financially aligned system that produces more efficient and higher quality care outcomes. Select Health is uniquely positioned to provide solutions for each of these key factors.

Leveraging Select Health's experience serving the needs of South Carolinas, we can help SC DHHS implement a successful dual demonstration. We have solutions to each of the key factors SC DHHS has identified as pivotal to its success in overcoming its challenges.

PROVEN PROGRAMS DESIGNED TO DRIVE EFFICIENT AND HIGH QUALITY CARE

- Our proven cost-effective programs align financial incentives and place the customer at the center of care.
- Our programs help providers give more effective care. We consistently improve HEDIS® rates in the markets we serve and some rates for asthma, diabetes, cardiovascular disease and COPD.
- We implement proven innovative programs that help members achieve their care goals.

ENGAGED AND COMPREHENSIVE PROVIDER NETWORK

- Our current network provides South Carolina beneficiaries care across all 46 counties

- Much of our existing network has voiced an interest in deepening its relationship with Select Health and taking part in our multidisciplinary care teams
- Access issues will be further mitigated through our rural outreach and telemetric services

INFRASTRUCTURE AND EXPERIENCE SHARING MEMBER AND PROVIDER-LEVEL DATA

- We have a fully developed information technology platform allowing for comprehensive member care documentation
- We have extensive experience in pushing health information to both regulating entities and providers

EXPERIENCE CREATING FINANCIAL ALIGNMENT BETWEEN CARE PARTNERS

- We have documented success in aligning incentives with member outcomes

PART 1 - TELL US ABOUT YOURSELF (RESPONDER/RESPONDING ORGANIZATION):

B. Provide a general high-level description of the organizational components required to successfully operate a CICO under the SCDuE Demonstration. Responses should address the core elements of an integrated system of care outlined within the SCDuE Demonstration Proposal.

Select Health's organization and infrastructure is successful, flexible and scalable to meet the needs of the Demonstration. Through our successful implementation and support of Medicaid Managed Care programs in multiple states — Pennsylvania, South Carolina, Indiana, Kentucky, Louisiana and New Jersey — as well as with CMS and the launch of our Medicare product, we have significant and recent experience in identifying key business components to operate new lines of business and bringing those components to fruition.

To meet the requirements of the Demonstration, including the core elements of the system of care, Select Health believes the following components are required.

QUALITY IMPROVEMENT AND MEDICAL MANAGEMENT

CICOs must work closely with PCMHs to develop and execute care plans that not only manage members' health, but also proactively provide early screenings and coordinate a member's care across the entire care continuum. The ability to adequately develop this Model of Care to manage and ensure members' quality of care will be key in achieving the goals of this demonstration.

NETWORK DEVELOPMENT

Successful organizations must develop a robust provider network with the correct composition of physicians, specialists, and hospitals to serve the population. The network will need to be analyzed in support of the CICO's strategies.

INTEGRATED HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

Success of CICOs depends on their ability to collect key information on members, analyze and take action from that information as well as share it with all key constituents including the member, SC DHHS, CMS and all members of the interdisciplinary care team

PART 1 - TELL US ABOUT YOURSELF (RESPONDER/RESPONDING ORGANIZATION):

C. Provide a general high-level description of your organizations' experience and/or expertise with the coordination of care across a continuum of health care services (i.e., primary care, behavioral health and long term care services). Responses should include a description of the administrative, managerial and operational functions employed as part of care coordination.

Select Health, together with its corporate parents and affiliates, brings nearly 30 years of unparalleled experience to the development and operation of managed care systems across the continuum of care. Select Health is a wholly owned subsidiary of AmeriHealth Mercy Health Plan, one of the largest organizations of Medicaid managed care plans and related businesses in the United States. Enterprise-wide, AmeriHealth Mercy touches the lives of four million members.

Select Health first began serving South Carolina's Medicaid population 16 years ago. Select Health now serves over 235,000 members, and is on the edge of launching its Medicare D-SNP, in January, 2013.

Select Health's experience is described immediately below, followed by a summary of the managed care experience of Select Health's affiliated plans.

SELECT HEALTH OF SOUTH CAROLINA, INC.

Select Health of South Carolina, is the state's first and largest health insurer, managing the delivery of healthcare to more than 235,000 members across the state. Our members receive a more robust benefits package than would be provided under a traditional fee-for-service system, such as health education and nurse support. Our network is vast and diverse, capable of caring for the most complex beneficiaries. Members enjoy a comprehensive provider network comprised of over 60 participating hospitals; over 2,000 unique primary care providers; 4,500 unique specialists; and more than 900 pharmacies.

Select Health serves the most medically fragile Medicaid members in the state. Select Health members with chronic conditions are enrolled in our Care Coordination program through which they receive guidance and support in managing the following conditions: Asthma; Diabetes; Cardiovascular Disease (Health Failure/Heart Risk); HIV/AIDS; Sickle Cell; Hemophilia; and Pregnancy with co-morbid conditions. Members with multiple chronic illnesses are enrolled in our Intensive Case Management Program where they receive intensive interventions through an interdisciplinary team consisting of our Care Managers, Medical Director, pharmacists, and practicing physicians. External agencies involved in the members' care also participate on the care team as needed.

Select Health identifies members for Care Coordination with state-of-the-art technology focusing on those members at-risk for future adverse health events. We proactively identify care gaps that, if not addressed, could result in an otherwise avoidable ER admission or hospitalization. We have taken these efforts outside our own organization with our deployment of the Member Clinical Summary (MCS) to participating primary care physicians. The MCS is a web-based electronic medical record

that integrates claims data, pharmacy data, and care gap data, and presents the information in a usable format to the treating physician or provider.

Select Health is fully integrated in the communities we serve. Recognizing that healthcare is local, we have maintained our centrally located office in Charleston. We perform all medical management, provider network management, and health education and outreach functions from this location. We staff this office with associates who live in communities we serve, and by virtue of living and working in the region, are familiar with regional differences in healthcare delivery and the needs of the community. Our Provider Contracting and Community Outreach Representatives spend the majority of their time in the field, meeting with our members and providers. Our Medical Management team members also spend considerable time in the community, meeting with participating providers and working directly with our members.

Select Health has close relationships with Health Ministry Program for Women, March of Dimes and Family Connection of South Carolina. Select Health regularly works with these community organizations, as well as others, to offer community-based health education workshops. These self-empowerment educational workshops cover chronic conditions; hopefully supporting members understand their disease states and how to best achieve their care goals. In Select Health affiliated plans, these chronic conditions - including asthma, diabetes, heart health, women's health, maternity education, and poison prevention (including lead poisoning), as well as childhood obesity, medication safety, teen health and youth sports safety - are also part of the provider Pay-for-Performance program.

Select Health received National Committee of Quality Assurance's (NCQA) Excellent Accreditation as well as its Multicultural Healthcare Distinction. Select Health has also received the "Best Places to Work in South Carolina:" distinction for the last four years.

Select Health is led by a highly experienced team of care coordination, managed care professionals who currently manage our Medicaid business and will begin day-to-day management of our Medicare product, post go live January, 2013. Perhaps most importantly, our Executive Director for Select Health has extensive care coordination and managed care experience.

Mike Jernigan, President and Chief Executive Officer. Mr. Jernigan has over thirty years of progressive experience in the health care industry in the areas of financial management, business analysis, strategic planning and government relations. His in-depth, executive-level experience in strategic management, problem solving, negotiating, leadership and organizational management was an instrumental force behind the successful creation and implementation of Select Health of South Carolina, the state's first and largest managed Medicaid health plan. As Southern Regional President Mr. Jernigan's progressive and in-depth financial management and analytical skills, coupled with his extensive government relations experience will provide invaluable support and guidance for this demonstration project.

Cindy Helling, Executive Director. Ms. Helling serves as Select Health of South Carolina's Executive Director and has been employed by the company since its founding in 1995. Ms. Helling's leadership was a driving force behind Select Health's successful growth, now covering over 235,000

Medicaid recipients in South Carolina. Her expertise in strategic planning and project implementation will ensure the Dual Demonstration project is successful.

Rebecca Engelman, RN, BSN, Vice President of Operations. Ms. Engelman is responsible for the overall leadership of operations for Select Health of South Carolina. Ms. Engelman led Select Health to become the first NCQA accredited Medicaid Health Plan in South Carolina, maintained at the Excellent accreditation level. Her clinical background combined with operational excellence will ensure a successful implementation of the demonstration project.

Fred Volkman, M.D., Chief Medical Officer. Dr. Volkman has thirty years of progressive experience in the management, provision, and promotion of integrated health services in a variety of settings including Medicaid managed care. He has proven expertise in clinical strategy, provider relations and pay-for-performance program design. As Southern Regional Medical Director, he will bring these talents to the demonstration project in his clinical oversight role.

MEDICAID MANAGED CARE EXPERIENCE OF AMERIHEALTH MERCY AFFILIATES

The AmeriHealth Mercy Family of Companies' exclusive focus throughout their history has been on low income populations. AmeriHealth Mercy's in-depth experience includes managing health care service delivery for Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP), and (for more than 12 years) the Aged, Blind, Disabled (ABD) and dually eligible population, serving over 1.4 million of these members in six states. The members of the AmeriHealth Mercy Family of Companies include: Keystone Mercy Health Plan (KMHP), AmeriHealth Mercy Health Plan (AMHP), Select Health of South Carolina, MDwise Hoosier Alliance, AmeriHealth Mercy of Louisiana (LaCare), PerformCare, PerformRx, and AmeriHealth Nebraska (Arbor Health Plan).

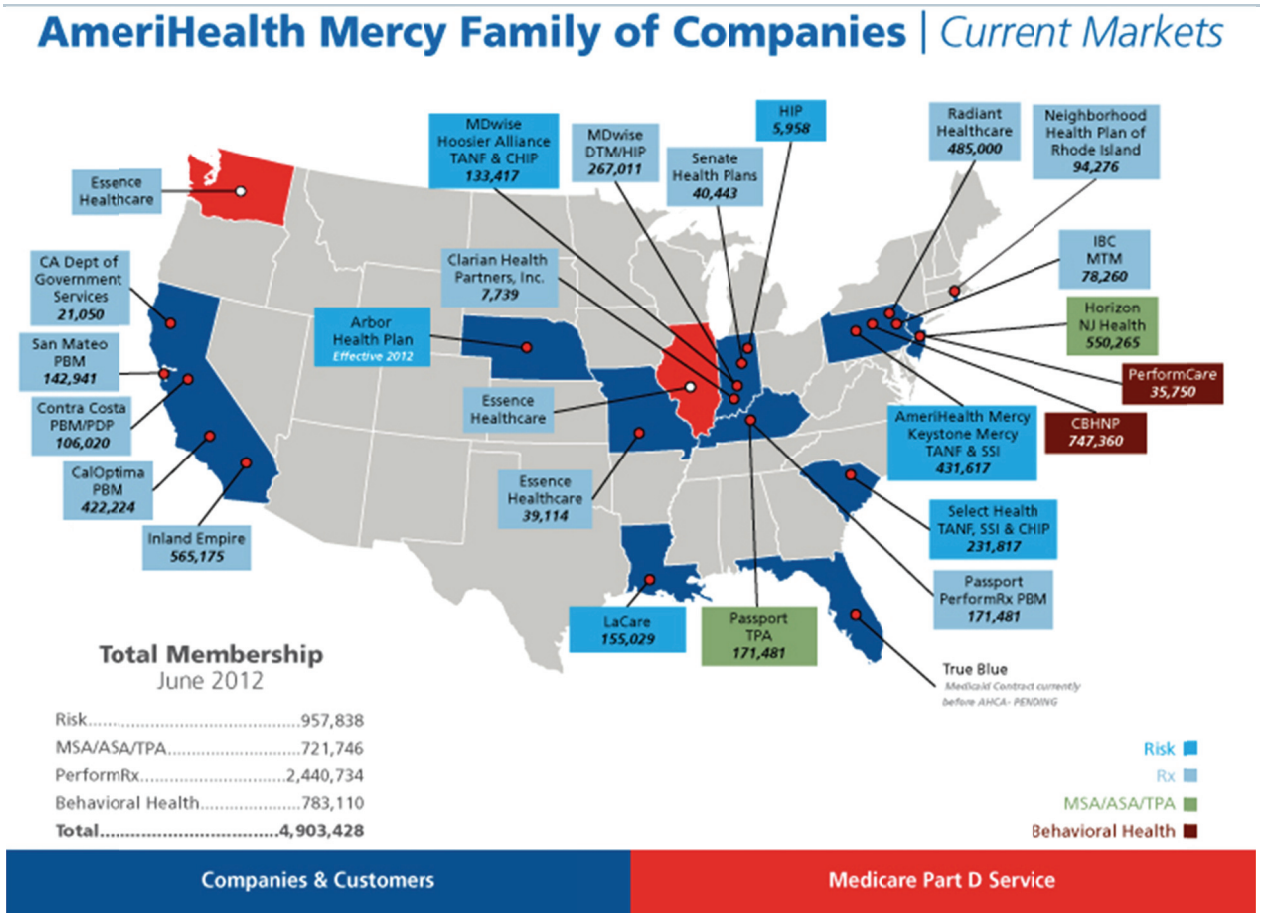

Figure 1: AmeriHealth Mercy Family of Companies, Current Markets

COORDINATION OF CARE

Select Health uses an Integrated Care Management (ICM) model that integrates physical health (including long-term care), behavioral health, and social/environmental aspects of the enrollee's care into one comprehensive plan of care. We structure our care management team to include individuals with backgrounds and expertise in behavioral health, physical health, and social work. Our ICM model uses evidence-based practice, well-defined processes and procedures, and builds upon the concept of "connections" to ensure that enrollees are connected to the appropriate providers, that providers themselves are connected with other providers involved in the enrollee's care, and that any other resources are available which may be applicable. Our Care Management employees are responsible for ensuring that all appropriate connections are in place to support the enrollee throughout the treatment process.

To address the complex issues surrounding care of enrollees, our model draws on the following elements:

- Expertise of a multidisciplinary team with clinical experience in caring for the special needs of this population
- Strong relationships with local providers and organizations that care for these enrollees
- Integrated software support to facilitate an active ICM program

Select Health has been involved in transitions to managed care from other delivery systems and understands that transitioning health care services must appear to be seamless from the point of view of the enrollee. An interruption in required services should never occur; to ensure such a result, Select Health has established and successfully employed mechanisms to: (a) identify enrollees with special health care needs; and (b) ensure that those enrollees continue to receive all medically necessary services. Our reporting and assessment systems are designed for and operate in a manner which allows us to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

For our special needs members, we encourage the establishment of a patient-centered medical home and connect the enrollee to a highly effective PCMH case manager. Establishing a PCMH promotes the access to and coordination of preventive and chronic care services for every enrollee through personally selected health care professionals.

Establishing seamless care coordination and assuring access to care for our special needs and chronically ill enrollees is an organization-wide commitment. Our approach for special populations is to:

- Enroll members in PCMHs and work as an interdisciplinary team to meet member care goals.
- Maintain a comprehensive network of participating providers and partner with those providers to ensure our enrollees receive the care and services that they need.
- Provide effective care management and chronic disease management programs for members with complex chronic conditions and behavioral/physical dual diagnoses, and for medically fragile members.
- Develop collaborative relationships and coordinate services with other human services and health care agencies through the establishment of an integrated care team.

COORDINATION WITH HCBS WAIVER PROGRAMS

Select Health is committed to collaborating and partnering with local and State agencies to supplement services not covered by the demonstration capitated rate. As a matter of standard practice across our programs nationwide, we work with local and State agencies to ensure that enrollees who have any special health care needs have access to community resources. We also provide enrollees with special health care needs access to a PCMH Care Manager who will assist the enrollee in coordinating care with outside resources.

We have committed to partnering with SC DHHS and the assigned waiver case manager to work together on joint goals of improving the health status and outcomes for our enrollees.

PART 2 - QUESTION I: CONSUMER ISSUES

1. What are the most effective uses of a) Enrollment Brokers and b) Aging and Disability Resource Centers (ADRCs) in providing enrollment options and counseling and Beneficiary education to potential enrollees in the Dual Eligibles Demonstration?

Select Health of South Carolina is well positioned to improve the care of this population and is looking forward to working with enrollment brokers as well as the ADRCs to ensure members are matched to the CICO best positioned to meet their needs. The enrollment brokers and ADRCs will be our 'first line of defense' in creating a meaningful and trusting connection with our new members.

ENROLLMENT BROKERS

The greatest benefit of an enrollment broker is the ability to provide objective information to recipients in selecting the best CICO for their needs. For the enrollment broker to be successful with this member connection, the CICO will need to partner closely with the enrollment broker to ensure they are well educated on the plan and its participating providers. Enrollment brokers are well positioned to begin the discussion of patient-centered medical homes and care continuity by working with the member to keep them connected, if possible, to their current PCP or to find a PCP that is a reasonable substitute.

Select Health's core system infrastructure can be scaled to meet the membership requirements. It is also versatile enough to meet business requirements around inbound and outbound eligibility files and connectivity with SC DHHS and any other key parties. This infrastructure will support the enrollment brokers' real-time access to our current list of primary care providers.

To ensure the enrollment brokers are comfortable with these systems, it will be important for them to be trained and for complete system testing to occur prior to open enrollment.

AGING AND DISABILITY RESOURCE CENTERS

As part of this demonstration project, it will be important to engage members and educate them on resources that were not previously available to them. These resources have the potential to dramatically improve the health of these members. However, we cannot force them to seek appropriate health care or to change unhealthy habits. The process of change evolves over time by empowering members with information and educating them to the value of those changes, while providing them with supportive resources.

The Aging and Disability Resource Centers (ADRCs) are well positioned to provide members with information on the full range of options available to them. ADRCs should partner with the enrollment brokers, and the enrollment brokers should provide training to the ADRCs regarding the demonstration, which the ADRCs would use in their education process. Select Health does not see the ADRC serving an actual enrollment function, but simply as a trusted educational and non-biased resource for potential members.

PART 2 - QUESTION I: CONSUMER ISSUES

2. Provide a description of the provider, Beneficiary and stakeholder education and outreach strategies your organization would employ prior to this Demonstration's implementation. Responses should include considerations for the rural nature of the state and the need for effective and efficient communication among all parties.

Select Health has a proven track record for educating provider networks, beneficiaries and stakeholders and implementing operations that provide quality service to South Carolina consumers. We serve as a partner to the provider community and an advocate for our members and will expand these roles to meet the unique needs of the Demonstration. Using our established provider networks and health plan operations as the foundation, we will build on that base to support the membership and meet requirements of the demonstration. This will allow us to quickly expand our existing reach and execute the unique needs of the program.

As part of our mission to build healthy communities, we contract with community-based providers, with particular attention to those who are culturally competent and understand the backgrounds and needs of our members.

As a result of our current experience in South Carolina, a majority of the educational materials for providers and beneficiaries have already been developed and will only need to be modified to meet the specific needs of the Demonstration project.

OUTREACH STRATEGIES

Select Health has a 16 year history of community engagement, education and outreach with our team of Health Benefit Educators. Prior to this demonstration's implementation, Select Health will develop and implement community outreach strategies tailored to the unique needs and culture of the demonstration population. Our outreach approach will focus on expanding our existing community partnerships, developing new relationships and creating an awareness of the benefits of managed health care on this population. We will use grassroots educational outreach strategies to promote wellness as a lifestyle, increase the target audience's knowledge of managed care while using media and community outreach to increase awareness of health or nutritional information, health care services and preventive screenings to encourage healthy living in the communities we serve.

Our outreach plan features an integrated combination of strategies, which include community health fair and event participation, advertising and public relations, as well as provider marketing and community partnerships with advocacy groups. All such activities would be conducted with appropriate approval.

Community Health Fair and Public Events Strategy

Our Community Outreach Team participates in health fairs and public events, with appropriate approval only. Our Dual Eligible strategy is designed for Select Health to expand our permanent and consistent state-wide presence communities and to continue preventive health messages, access to preventive screenings and health education programming in familiar and convenient locations.

The idea is to build upon the existing synergy between Select Health and community partners and services to include this additional population. This synergy produces an increased awareness of health prevention and healthy lifestyles for both our members and the community as a whole.

Key Stakeholder Community Advocacy Strategy

Select Health's education outreach program will expand, targeting community, elected officials, advocates, faith-based and human service agencies, subject to the requirements of demonstration. The primary purpose of this outreach strategy is to enhance awareness of the availability of health care coverage through managed care and to help stakeholders understand available programs and how to access available services.

Partnerships with community-based organizations are a valuable resource and a vital link for enrollees who face language, cultural, literacy or numeracy barriers, live in rural areas, need extra assistance or do not trust governmental organizations. Our objective is to provide the resources and education necessary for community-based organizations to serve as an effective and accessible bridge for potential members so they can be educated and interested in participating in the demonstration.

We will ensure all of our educational activities comply with applicable requirements, and we will obtain all necessary approvals prior to implementing them.

Provider Education and Marketing Strategy

Select Health believes that it is crucial to engage and create true partnerships with our providers. With that as our guiding principle and as an integral part of our efforts to both attract and educate providers, we will continue partnerships with key participating providers to increase awareness about the demonstration. Additionally, we will expand the following marketing initiatives to include the Dual Eligible population:

- Co-sponsor health fairs with PCPs
- Conduct targeted health promotion and education programs
- Conduct PCP orientations
- Distribute plan information and educational materials

Communications and Advertising Strategy

Select Health also utilizes a communications and advertising strategy to increase community awareness. With a combination of various types of approved paid and free media, which reach into all of the communities that we serve, we will ensure that beneficiaries understand the goals of the demonstration.

We continually research and evaluate the use of billboards, radio advertisements, transit advertisements, print advertisements in daily and weekly newspapers (including Spanish-language and other ethnic publications) and television advertisements.

Website

Select Health's website will also be a valuable resource for our potential members and providers. Our website will be interactive and informative while remaining fully compliant with requirements and policies and procedures. Some of the features will include:

- Member health information and online newsletter
- Calendar of events
- Health education materials
- Member handbook
- Provider directory
- Provider section
- Access to member and provider portals

We anticipate the website will initially be most useful in communicating with providers, but its content will include enrollee materials, including the preferred drug list, provider directory and enrollee handbook(s), as appropriate and available.

PART 2 - QUESTION I: CONSUMER ISSUES

3. What strategies does your organization consider particularly effective for encouraging consumer participation?

Communication is paramount. At Select Health, we believe members who understand their care and health needs are more likely to take proactive steps to control a chronic disease or to remain in a healthy state. Partnering with providers and their patients, connecting all parties with technology and information can change the way members see and control their health. Our goal is to encourage independence and personal responsibility to promote positive health outcomes and control program costs. Our strategy focuses on empowerment through engagement and education and is interwoven in all components of our clinical programs. This is coupled with innovative and award-winning community-based wellness programs and consumer incentives to engage members in taking control of their health. Our prominent programs and incentives are described below.

INTEGRATED CARE MANAGEMENT

Select Health's Integrated Care Management model actively engages members in care planning to empower them to take responsibility for their care. Our engagement strategy begins with asking the consumer to identify personal goals rather than "health care" goals. By focusing on the consumer's concerns, like wanting to walk a child to school or climb stairs, the care manager can address items such as dietary changes required for healing a diabetic consumer's foot wound or proper use of asthma medication.

Consumers who can actively participate in the care plan are assigned a specific role. For instance, the care manager may ask a consumer with heart failure to call each week and report his/her weight. During the call, the care management team supports the consumer by positively reinforcing his/her activities, helping to instill a sense of accomplishment. These interactions help members maintain an open, active dialogue that leads to improved care.

MEMBER WEB PORTAL

To help consumers manage their healthcare, the Member Web Portal gives members the ability to view their medical history including their care gaps. Care gaps are services that are recommended by nationally-accepted clinical guidelines for which there is no claim evidence that the consumer received the service. This information is available as a printable Member Clinical Summary that members can take to their physician appointments.

Our Member Web Portal also provides state-of- the-art interactive tools to perform self-service for specific activities and includes a robust Health and Wellness section, with information about preventive care, wellness strategies and management tips for living with a chronic condition.

MEMBER WELLNESS PROGRAMS AND INCENTIVES

Select Health effectively engages members in their own health by partnering with them and with community leaders, faith-based organizations and agencies already trusted in the community. By establishing a relationship of mutual trust, we help the consumer become an active participant in their care. A key component to all of our programs is a specific and clear call to action. Several of our programs are described below.

- Healthy Hoops® - Our NCQA award-winning program uses basketball to educate pediatric members with asthma and their families about asthma management and obesity prevention.
- Lose-to-Win - Our URAC award-winning program uses a contest format loosely mirrored on TV's "Biggest Loser" to educate and engage members with type-2 diabetes and obesity on nutrition and exercise.
- Women's Health Ministry 40-Day Journey - This NCQA-recognized program focuses on improving the health of African-American women and their families through a multi-week educational series emphasizing nutrition, exercise, medication compliance and water intake.
- Know Your Numbers - This program stresses the importance of knowing key health numbers, including blood pressure, cholesterol level and blood sugar level.
- Prepare For Your Visit -This personal responsibility program provides an easy-to-use guide to help a consumer ask the right questions during their doctor's visit.
- 4 Your Kid's Care - Our newest program, 4 Your Kid's Care, provides young mothers with hands-on training and education on how to care for a sick child at home. Focused on reducing inappropriate emergency room utilization, this program offers educational sessions in local community venues and train-the-trainer sessions for community-based organizations.
- Smoking Cessation and Nutritional Support – This support program provides members with 70 tobacco cessation counseling sessions per calendar year without referral or prior authorization. Members who are eligible for pharmacy services can get tobacco cessation medicines. We also provide our members with access to registered dieticians and nutritional counselors.

Select Health uses health incentives to increase members' motivation and willingness to change and maintain healthy lifestyles. We adjust our consumer incentive programs over time based on our retrospective evaluation of the effectiveness of each incentive and ensure that incentives target those areas most in need of improved outcomes. Examples of these member incentive programs include providing members with gift cards for completion of relevant mammography screenings, HbaIC blood tests and LDL blood test.

CONNECTING THE MEMBER TO A PROVIDER

Select Health continually promotes an open dialogue between providers and enrollees. It is imperative to positive health outcomes that the first encounter an enrollee has with the system of care that serves him or her occurs early, thereby providing an opportunity for the physician to get to know the enrollee through a health assessment and identification of needs. This in turn results in the connection of the enrollee to a patient-centered medical home and the establishment of a plan of treatment in conjunction with preventive, case management and disease management programs, as appropriate. We have numerous mechanisms in place to facilitate communication between providers and their patients. Promoting continuity and coordination of care in this early encounter begins the important relationship between the enrollee and PCP.

Some of the interventions we use to encourage early PCP visits are:

- **Direct Mail.** Periodic mailings that encourage enrollees to set up an appointment with their PCP.
- **Enrollee Handbook.** Addressing the importance of the medical home and urging the scheduling of a visit with their PCP in the enrollee handbook.
- **New Enrollee Welcome Calls.** Within 30 days of receiving the enrollment file, our enrollee service representatives attempt to contact each enrollee household by phone to explain plan benefits, including the importance of scheduling an early visit with their PCP.
- **Warm Transfer/3-way Calls for Initial Appointment Scheduling.** We can warm transfer calls directly to the PCP's office or hold a three-way call between our representative, the enrollee and the PCP office upon completion of the orientation call, so enrollees may make necessary appointments without having to call directly. We also leverage this tool of enrollees indicate they have difficult expressing themselves the provider or if they indicate they do not understand what their provider has said to them.
- **Provider Assignment.** We assist enrollees in selecting new PCP when requested, possible and appropriate.
- **Roster Communication with Every PCP Office.** Providers are able to access rosters via the provider portal or may request hard copies. Rosters highlight the importance of reaching out to enrollees if they do not already have an appointment scheduled.
- **Care Gap Reports and Alerts.** PCP offices can access reports of their assigned enrollees who have not had recommended well-care visits. This information helps offices proactively contact and schedule enrollees as part of their medical home responsibilities.
- **Provider and Community Education Efforts.** Provider Service staff also reinforces to all PCPs and their staff members during orientation and throughout their relationship with Select Health the importance of scheduling new enrollee appointments.

PART 2 - QUESTION I: CONSUMER ISSUES

4. Provide a description of the specific mechanisms CICOs should have in place to support a person-centered delivery model.

Select Health's model of care places the member at the center of the model, connected to a primary care practitioner (PCP), working with us to provide and coordinate a centralized spectrum of services to include acute, chronic and specialized treatment. This results in the connection of the enrollee to a patient-centered medical home and the establishment of a plan of treatment in conjunction with preventive, case management and disease management programs, as appropriate.

We have numerous mechanisms in place to facilitate the coordination of this person-centered delivery model, explained in more detail below.

ABILITY TO MANAGE PCP ASSIGNMENT

A crucial element in ensuring members have ready access to the right kind of care is the connection between the member and the PCP. Developing a strong relationship between enrollees and their PCPs is one of Select Health's fundamental goals, and it starts with the assignment of the PCP.

During the enrollment process, we will assure that all enrollees are linked to a PCP, and we will assist enrollees in selecting a PCP when requested, possible and appropriate. For members with disabling conditions, chronic illnesses or other special health care requirements, we will work with them to select specialists as a PCP, as appropriate.

Select Health also monitors enrollment files and ensures members are assigned to PCPs. However, if no PCP is indicated on the enrollee file, Select Health will execute a direct follow-up process with the member to speak with him or her and coach the member through a PCP selection process. In extreme cases, where members are not reachable, we will ultimately auto-assign a member to a PCP and change our outreach strategy to scheduling an appointment between the member and new PCP. Auto-assignments are always completed in consideration of a member's history with particular providers, any familial PCPs, cultural needs, and geographic location.

ABILITY TO SUPPORT PCMH FUNCTIONALITY

Select Health is a national Medical Home Pioneer and was founded on the principles of the Medical Home Model. True to our roots, Select Health has remained in the forefront as this concept.

Provider Portal and Member Clinical Summaries

Select Health will assist providers with data to allow them to know our members individually, but to also collect demographic and clinical data for purposes of population management. Through the Provider Portal, PCPs will have a 360-degree view of their panels with access to clinical information about all their Select Health members. They can access the Member Clinical Summary that shows all medical services including those from other providers and specialists that an individual member has received. The Member Clinical Summary can be printed for inclusion in the patient's chart or

downloaded as a Continuity of Care Document (CCD) for integration into an electronic medical record.

A simple check of eligibility will notify a provider if that member is missing a recommended preventive care or chronic care monitoring service. Any time a PCP accesses our system for an individual member , a message will pop up alerting the PCP to the needed service if there are gaps in that member's care.

In addition, PCPs will be able to access this information at the panel level, allowing them to use population management techniques within their practice.

Care Management

Select Health has an array of care management employees that support our providers in assisting members with special needs, chronic care needs and disease specific conditions. PCP involvement in such programs is imperative, and we communicate the following to providers about the expectations of the program: This proactive medical care coordination program focuses on Select Health members with specific health risks.

Providers are responsible to participate in the program through:

- Providing relevant clinical information, as requested
- Taking action to follow-up on reported information
- Participating in the member/consumer plan of care

Based on the illness and the severity of illness of the members, the provider may be contacted to refer patients to us for participation in one or more of our Integrated Care Management programs. These programs are intended to be a collaborative arrangement between our care managers and the provider's existing treatment plans for the involved members and will in no way impede on provider autonomy to provide care to members.

Performance Reporting and Incentives

Select Health utilizes comprehensive provider profiling. Provider profiles are available via the Provider Portal and allow providers full ability to track their performance across multiple metrics: HEDIS® measures, hospitalizations, ER utilization.

We work with providers to ensure they are educated on the data they review so that they can turn the data into actionable information to change the way they deliver care in their practices. We also have a number of provider focused incentive plans that financially incent providers to close care gaps and to ensure that they are providing members care when they need it.

Reimbursement Strategies

Select Health and Select Health's affiliates are developing PCMH reimbursement strategies to provide a financial incentive and reward for practices who achieve NCQA Medical Home certification. One pilot is a reimbursement strategy that includes a management fee per member per

month and offers provider payment for services not typically paid, such as consults and participation with team conferences.

Interdisciplinary Care Team

The Select Health Interdisciplinary Care Team (ICT) is a group of professionals, paraprofessionals and non-professionals who possess the knowledge, skill and expertise necessary to accurately identify the comprehensive array of the beneficiary's needs, identify appropriate services, and design specialized programs responsive to those needs. The composition of the ICT varies according to the beneficiary's individual care needs. In addition to the beneficiary and/or caregiver, ICT members may include health plan physicians, nurses, social workers and pharmacists, the beneficiary's PCP, specialists and ancillary providers involved in the beneficiary's treatment and community resource staff. In working with the South Carolina demonstration members, this team will be expanded to include the HBCS care managers.

The beneficiary and/or caregiver are involved in ICT discussions through participation in ICT meetings and via updates from the care manager. ICT meetings are held as frequently as needed based on the beneficiary's clinical situation and care needs. The care manager documents the discussions and decisions from ICT meetings in the information system. In addition, the results of home health assessments and physical therapy evaluations received by the care manager are summarized in the notes and the original documents are maintained as electronic images. Notes outlining information gathered and actions taken by the Rapid Response Team are also part of the system. Additionally, information received from community agencies and service organizations related to the beneficiary's plan of care is included.

To promote beneficiary access to the ICT, Select Health uses a Rapid Response Team (RRT), consisting of specially trained care connectors and care managers. Beneficiaries access the RRT through a toll-free number that is answered by a live person within 30 seconds. Rapid Response staff facilitate connections to needed services, assist with transportation arrangements, troubleshoot barriers and serve as a secondary-access point to Select Health programs. Typical issues addressed by the RRT include access to medications, transportation needs, and assistance making appointments.

Select Health also employs several outreach strategies designed to keep the beneficiary involved with the ICT. Select Health beneficiaries who have not seen a PCP recently are contacted and encouraged to make an appointment for an annual physical and health check.

Claim and assessment data is analyzed to identify unmet preventive health needs and recommended chronic condition monitoring. Beneficiaries identified through this process receive outreach via phone and mail to remind them of the needed service and assist them in making the necessary arrangements for care. In addition to these beneficiary-specific outreach efforts, Select Health runs annual outreach campaigns to promote population-based health needs, such as flu vaccination promotion and reminders.

PART 2 - QUESTION I: CONSUMER ISSUES

5. Continuity of care between Demonstration services and Home and Community-Based waiver Services (HCBS) is a high priority issue. However, management of HCBS are carved-out of Demonstration services. How would your organization support consumer choice and participation in this crucial area of system interface?

As discussed in question #4 above, Select Health of South Carolina's model of care places the member at the center of the model, connected to a primary care practitioner (PCP), working with us to provide and coordinate a centralized spectrum of services to include acute, chronic and specialized treatment. This results in the connection of the enrollee to a patient-centered medical home and the establishment of a plan of treatment in conjunction with preventive, case management and disease management programs, as appropriate.

Continuity of care is critical to success and must include services that are carved-out of Demonstration services. Members who qualify for HCBS are some of the most fragile elderly and will need to access HCBS on an ongoing and consistent basis in order to remain in their home. Select Health believes the most important aspects of consumer choice and participation is education and engagement.

The model of care is supported by a variety of staff across the organization including those in administrative roles, clinical roles and those in oversight roles. These individuals provide key functions that create the Interdisciplinary Care Team (ICT). The ICT is a group of professionals, paraprofessionals and non-professionals who possess the knowledge, skill and expertise necessary to accurately identify the comprehensive array of the beneficiary's needs, identify appropriate services and design specialized programs responsive to those needs. These functions will all have accountability to department directors at the local level and will have additional oversight through the business president.

The composition of the ICT varies according to the beneficiary's individual care needs. In addition to the beneficiary and/or caregiver, ICT members may include health plan physicians, nurses, social workers and pharmacists, the beneficiary's primary care physician (PCP), specialists and ancillary providers involved in the beneficiary's treatment and community resource staff. In working with the South Carolina demonstration members, this team will be expanded to include the HBCS care managers and any relevant community long term care contracted case managers. Additional integration of the Phoenix and Care Call systems will ensure that all key elements of the beneficiaries' care experience is documented and integrated.

The beneficiary and/or caregiver are involved in ICT discussions as well through participation in ICT meetings and via updates from the care manager. ICT meetings are held as frequently as needed based on the beneficiary's clinical situation and care needs. These meetings are also wonderful opportunities to work as a team to ensure beneficiaries are aware of how and when to access the HCBS system. This furthers their ability to take control of their care and make their own care choices.

To promote beneficiary access to the ICT, Select Health uses a Rapid Response Team (RRT), consisting of specially trained care connectors and care managers. Beneficiaries access the RRT through a toll-free number that is answered by a live person within 30 seconds. Rapid Response staff facilitates connections to needed services, assist with transportation arrangements, troubleshoot barriers and serve as a secondary-access point. Any actions initiated by the RRT are shared immediately with all members of the ICT to ensure follow-up with any needed action items. An ICT meeting can also be scheduled, if required.

Select Health also employs several outreach strategies designed to keep the beneficiary involved with the ICT. Beneficiaries who have not seen a PCP recently or have unmet preventive health needs and recommended chronic condition monitoring needs are engaged via phone and mail to remind them of the needed services and offering assistance in making the necessary arrangements for care.

PART 2 - QUESTION I: CONSUMER ISSUES

6. Per CMS requirements, a minimum of two CICOs must be offered to South Carolina's Dual Eligible Beneficiaries for the SCDuE Demonstration. What features would a CICO use to differentiate itself from other CICOs to Beneficiaries and providers?

There are several factors that differentiate CICOs. Comprehensive state-wide networks, provider engagement with the CICO, member engagement with both the CICO and their PCP, minimizing the hassle factor for members and providers, a visible presence in the state, consumer satisfaction and quality metrics all differentiate CICOs from one another.

Select Health of South Carolina has a long history of engaging both members and providers within the South Carolina market. Select Health's mission is to help people get care, stay well and build healthy communities, with a special concern for the needs of the poor. Select Health stands on the theory that engagement, education and empowerment will allow us to reach our mission.

Select Health is a mission-driven organization focused on the poor and helping members achieve their care goals. We have found that by partnering with local community organizations and liked-minded providers, we can develop an infrastructure of support that attracts additional members and providers.

More specifically, as we have grown in South Carolina, we have continued to meet with strategic providers. These are key providers of FQHCs, hospitals and health systems as well as key safety net providers in the community. We have long leveraged these relationships as the hubs of our provider network. We have used them to develop medical homes and information sharing processes. They provide the foundation for our various quality committees, setting policy and direction. By demonstrating our commitment to this population and by our willingness to clearly and honestly communicate with our providers, we have found a commitment from them and willingness from them to partner with us as we cover more and more members within the marketplace.

Additionally, we have a best-in-class back office administration function that works tirelessly to ensure that we demonstrate our respect for our providers – such as in timely claims payment and painless authorization processes –on a daily basis. We are proud to have created a positive reputation in the marketplace that has spread to additional providers and piqued their interest in joining our network.

Similarly, we work within the community to educate members and potential members on their health. We host hundreds of community events annually where members are able to interact with our care management team and begin to learn how and when they should seek care and how to stay healthy. This cut-above focus on engaging and empowering members – partnered with rich benefits – has made us a favorite within the South Carolina market, demonstrated by our continued Medicaid growth.

Select Health consistently achieves high consumer satisfaction and HEDIS outcomes, maintaining an Excellent NCQA accreditation status for its Medicaid members over the past three years. Our members express their satisfaction through high scores on consumer satisfaction surveys and through extremely low voluntary disenrollment rates.

We are incredibly sensitive to the fact that our reputation is only as good as the previous day's care and interactions. As such, we never lose focus on the member; we keep them at the center of the care process and make every contact with that member count. Only this way can we achieve our mission for our members to get care, stay well and build healthy communities.

II. WAIVER (HCBS) INTEGRATION:

1. Provide a description of the strategies your organization would employ to prevent unnecessary nursing facility admissions.

Select Health has a strong track record of supporting members with complex needs in the home setting. We currently coordinate care for enrollees who receive ongoing in-home services, ranging from caregiver support to nursing and ventilator care. Our approach includes aggressive planning, creative service delivery and ongoing monitoring and care management to minimize delays in service that often lead to poor health and costly admissions.

COORDINATING SERVICE PLANNING AND DELIVERY

Our planning process begins with a review of the member's health information. We identify all prior health care issues and past services, including services rendered immediately prior to any hospital admission.

Information gathered from the member's Care Coordination Survey included in our New Member Welcome Packet and completed during new member welcome outreach calls and other care management tools, provides a template of the member's needs and available supports, while data gathered from the member's treating physician, hospital social worker, and other involved healthcare professionals, provide a blueprint of care needs.

Transition managers help assess discharge needs and assists with arranging post-discharge care and physician appointments for those members needing long-term in-home care. After a discharge date has been established, we facilitate communication of the member's clinical condition and plan of care to the identified home health, durable medical equipment and specialty home care providers.

MEETING COMPLEX HOME HEALTH NEEDS

Select Health care managers assemble each member's personal support network, encompassing the services needed for the member to remain in the comfort of his or her own home regardless of complex needs. Skilled nursing facilities, home health agencies, DME suppliers and other health care providers each fill a crucial role.

ONGOING MONITORING AND CARE MANAGEMENT

Select Health maintains contact with those members receiving in-home services. Following a hospital discharge, our care managers contact members who are currently in a care management program, while our Rapid Response team contacts all other members. Staffed by care managers and non-clinical care connectors, our Rapid Response team is a specialized unit dedicated to assisting members to identify and overcome healthcare barriers through facilitation and empowerment.

These follow-up calls focus on medication reconciliation, checking the status of ordered home services, confirming physician appointments and determining how well the member and caregivers understand physician instructions. Through this outreach, we work to make sure the member has the tools needed to progress in the recovery phase of care and is prepared and able to use them.

All members receiving ongoing in-home care are enrolled in our Complex Care Management program. These members receive comprehensive and condition-specific assessments and reassessments, along with the development of short-term and long-term goals and an individual plan of care, created with input from the member, caregiver, physician, home service provider and, when applicable, waiver program care manager.

II. WAIVER (HCBS) INTEGRATION:

2. How would your organization utilize nursing facilities for short term stays?

Select Health's goal is to always provide the most efficient and high quality care to our members. Given the different circumstances affecting a member – from social to family to health – the right place for care is not always an obvious answer.

Select Health is committed to our members and dedicated to providing them with the right care at the right time. To that end, Select Health believes there are appropriate times to utilize nursing facilities for short-term stays. The following scenarios are ways in which Select Health would potentially utilize a nursing facility for a short-term stay:

RESPITE AND RELIEF SERVICES

Respite care provides relief or coverage for an overtaxed caregiver. This respite can take the form of a break for the caregiver or for an episode of caregiver unavailability. Intermittent respite services are available to provide families/caregivers with a break from their direct care responsibilities. Respite may be provided through arrangements with nursing care facilities or local home health agencies. For planned respite care, the family/caregiver and member have input into the location and duration of services. In emergency situations, a home health nurse or aide may be placed in the home for a period of time until admission to a nursing facility can be arranged. The goal for all members receiving respite services is to return to the home setting.

EMERGENCY ROOM DIVERSIONS

In certain cases, home care givers may not be the best form of care for a member. This could occur, for example, due to a member's increasing illness and the care givers lack of comfort in caring for the member at home. Without intervention and care integration, this scenario could easily drive the home care givers to call 911 or simply drive directly the member to the Emergency Room. To provide a needed level of care, without incurring a hospitalization, the care team can instead make arrangements to select facilities to allow the member direct admission from the home. With good care integration, the member can hopefully be stabilized, the home care team can be educated, and hopefully the member can quickly return home.

SUPPORTING CARE TRANSITIONS

At times, caring for a member at home can be overwhelming to the care team, especially if the care team is made up of family members who lack formal medical training. Although the goal is to get a member into the least restrictive care setting possible, sending a member home when the care team is not ready to provide care, can simply lead to a fast hospital re-admission. Additionally, there can be situations where a member is still too ill or weak to return home, and needs a period of recuperation. In both scenarios, the member's overall health outcome is improved by leveraging a nursing facility for a transitional period of time.

In addition to respite, Select Health provides several supplemental services designed to allow the member to remain in the least restrictive setting possible.

II. WAIVER (HCBS) INTEGRATION:

3. How would your organization utilize assisted living or a community residential care setting for this population?

As discussed in question #2 above, Select Health's goal is to always provide the most efficient and high quality care to our members. Given the different circumstances affecting a member – from social to family to health – the right place for their care is not always an obvious answer.

Select Health is committed to our members and committed to providing them with the right care at the right time. To that end, Select Health believes there are appropriate times to leverage assisted living or a community residential care setting. In addition to respite care, emergency room diversion and care transitions, as discussed in question 2 above, Select Health would potentially utilize an assisted living or community residential care setting when the member's needs make those services appropriate. The following scenarios are potential ways a member's needs may be best supported by an assisted living or community residential care setting:

INTERMEDIATE LEVEL OF CARE

Assisted living or community residential care is an intermediate step for members whose needs have exceeded the ability of the home care team but do not require the intensive services of a nursing home. Members would receive custodial assistance help with a limited number of daily activities in a more home-like setting than a nursing home and at a lower cost.

SUPPORT FOR INDIVIDUALS WITH LIMITED CAREGIVER RESOURCES

Select Health provides additional services in the assisted living or community residential care facility to allow the individual to meet the facility's level of functioning – but not pay the room/board charge.

ENSURING MEMBER SAFETY

Fragile elderly, especially those with advancing dementia, are at risk in their home environment. Members living in assisted living or community residential care receive services tailored to their special needs, including medication monitoring, proper nutrition and social engagement.

As always, the member and their complete multidisciplinary care team – including their home care team - are involved in the decision to stay in their home or utilize assisted living or community residential care settings.

II. WAIVER (HCBS) INTEGRATION:

4. What strategies would your organization employ to assist nursing facility residents with their return to the community?

South Caroline Department of Health and Human Services recently implemented the Home Again program, where recipients may be enrolled in Home and Community Based Services waivers. Home Again is facilitated through the use of transition care, crisis intervention, community living services, guided care nursing and other services. Select Health would facilitate nursing facility residents with their return to the community through the services offered by this program.

MEMBER AND CARE GIVER EDUCATION AND EMPOWERMENT

Admission to a nursing home can be a frightening time for the person admitted and their family. The CICOs role is to educate the member and their care givers so they can make an informed decision about the best care for the member and to understand what the process looks to like to transition that member back to the community.

SUPPORT TO ACHIEVE CARE GOALS

The longer a member resides in a nursing home, the more difficult it can be to return to the community. Early engagement of the member and their care team improves communication and trust, supporting achievement of care goals, including a successful transition to the community.

PLANNING

The interdisciplinary care team approach is essential for a member's successful return to the community. The team, including the HCBS care manager, will assess and develop a plan of care for the member and then also help coordinate needed services and ongoing monitoring of care once back in the community.

COORDINATION WITH HCBS

Coordination with HCBS is part of any successful member return to the community. Although HCBS are carved out of the CICO, we are partners in ensuring the safety and continued well-being of members returned to the community.

III. ADMINISTRATION AND TECHNOLOGY

1. What are the information technology (IT) systems your organization considers important for the CICOs and Patient Centered Medical Homes (PCMHs) to have in place for this Demonstration?

Select Health's enterprise Information Systems architecture is built based on our core business needs, providing the foundation to support our key health plan functions: Medical Management, Provider Management, Claims Processing, Reporting, Member Reconciliation, Revenue Management, and Administrative Compliance. Leveraging our fully integrated technology model, Select Health will have the capabilities and capacity to support PCMHs while being flexible to support the needs of an additional program and population.

The core functional areas considered important for the CICO's to have in place are listed in the matrix below which provides a cross-reference between CICO functional areas and the supporting system domains:

Table 1: CICO Functional Area –System Domain

CICO Functional Area	System Domain
Medical Management	
In-Plan Services	ZeOmega Jiva
Coordination of Care	ZeOmega Jiva, Verisk DxCG, E-Health Clinical Alerts
Special Needs	ZeOmega Jiva
Quality Management/Utilization Management (QM/UM)	ZeOmega Jiva, Treo Solutions
Provider Network Management	
Provider Network	Portico, Visual Cactus, Networx Pricer, Networx Modeler
Provider Services	NaviNet Provider Portal
Service Access	GeoAccess GeoCoder, by Ingenix Suite®, DirectoryExpert®, by Ingenix Suite
Healthcare Applications	
Claims Payment and Processing	TriZetto Facets, EXP MACESS™/Workflow and Imaging, iHealth Technology (iHT)
Data Warehouse	DataStage®, by IBM-Ascential Software Inc. ™
Enrollment Administration Manager (EAM)	TriZetto Facets
Claims Data Manager (CDM)	TriZetto Facets
PDE Data Manager (PDEM)	TriZetto Facets
MDE's Xpress Encounter Pro (ECP)	TriZetto Facets

CICO Functional Area	System Domain
Financial Reconciliation Manager (FRM)	TriZetto Facets
Special Status Manager (SSM)	TriZetto Facets
Risk Score Manager (RSM)	TriZetto Facets
RX Reconciliation Manager (RxM)	TriZetto Facets
HCC Risk Adjustment Manager (HCC RAM)	TriZetto Facets

MEDICAL MANAGEMENT

Select Health maintains fully integrated Medical Management and e-Health solutions that help manage the delivery of valuable clinical services and information.

ZeOmega Jiva Care Management

The ZeOmega Jiva (Jiva) Care Management application is a collaborative health care management platform for case and disease management, service coordination, preventive health and utilization management. Jiva's extensive capabilities, coupled with our robust analytic and data mining capabilities, form a comprehensive Care Management Information System for all members, including those with special needs. Highlights of Jiva's system capabilities include:

- Utilization Management
- Disease and Case Management
- Preventive Health

Verisk Sightlines DxCG Risk Solutions

DxCG Risk Solutions offers risk adjustment and prediction engines, used to analyze and quantify both financial and clinical risk. Built using powerful, validated medical and pharmacy classification systems, as well as proven predictive modeling methodologies. Features, capabilities and benefits of Sightlines are:

- Validated, predictive modeling technology
- Advanced analytics to manage risk, improve health outcomes, and contain costs
- Designed to integrate with third party systems, including home-grown financial and actuarial methodologies
- Assess the illness burden of individuals, groups and populations
- Identify cost drivers and allocate healthcare resource budgets

- Develop risk-based provider payment structures
- Measure and demonstrate the impact of care management programs
- Use predicted costs to set underwriting rates
- Develop risk-based provider payment systems

E-Health Solutions

Our e-Health Suite leverages technology to connect providers and the health plan. As described in greater detail below, the e-Health Suite allows Select Health to electronically connect all members of the Multidisciplinary Care Team, including the PCP. All key members of the team can access this information from any computer with an internet connection. This e-Health suite enables better care coordination, improves population health, increases access to care, improves quality outcomes, and helps control costs. The e-Health Suite can be customized to meet the needs of SC DHHS and the multidisciplinary care team members, and includes the following services:

Clinical Alert Services

This solution delivers the right information, on the right member, at the right time to the provider. Instead of waiting for a provider to "pull" relevant information on the member, this solution "pushes" information to the provider. The clinical alert service delivers information on care gaps to providers when they check eligibility online through the Provider Portal. The alert capability can be customized to deliver other types of clinical information and can be triggered by any transaction in the secure section of the portal.

Mobile Device Integration

Select Health's affiliated plan in Pennsylvania is piloting the integration of our Clinical Alert Service with handheld devices used by physicians for e-prescribing.

Panel Reports

A comprehensive reporting engine allows PCPs to create panel-level reports for their assigned enrollees.

Member Clinical Summary

Our Member Clinical Summary (MCS) is available to all elements of the multidisciplinary care team through the secure areas of our Member and Provider Web Portals. The MCS is a claim-based medical history for an individual member. Each MCS offers the user a broad view of the care the member has received across the continuum of providers. It includes a medication list, recent encounters, diagnoses, and Care Gaps.

Health Information Exchange

Key elements of our e-Health Suite are available in the Continuity of Care Document (CCD) format. The CCD can be integrated with any Health Information Exchange (HIE) that follows current standards. It can also be delivered for direct download to a provider's Electronic Medical Record (EMR)/Electronic Health Record (EHR) through our Provider Portal.

Treo Solutions

Treo is a Web-based suite of applications which incorporates the 3M methodology for identifying Potentially Preventable Readmissions (PPRs). Using sophisticated algorithms chains of admission and readmission, events are linked to generate rates of PPR for any hospital or group of hospitals versus the network or any segment of it. Treo also can identify Potentially Preventable Initial Admissions (PPIAs) and Potentially Preventable ER visits. Since the member is the basis for this data, we can also report the data by PCP, in order to identify PCPs with the most PPRs and PPIAs so that improvement opportunities can be explored with primary care providers. In addition TREO is used for analytics related to healthcare cost and quality outcomes at the provider level. The insights gained from the analytics are used to develop provider performance management strategies and hospital provider profiles.

PROVIDER NETWORK MANAGEMENT

The core applications of the Provider Network Management systems assist Select Health in providing services in the following areas: Provider Contracting, Provider Credentialing, Contract Pricing, Contract Modeling, Provider Data Management, Network Adequacy, and Provider Directory.

Portico

Foundational to managing our provider network is Portico's integrated provider management system, through which we are transforming how we manage provider information with the objective to minimize errors, lower costs, and improve provider performance and health outcomes.

Visual Cactus

Visual Cactus (CACTUS) maintains provider credentialing and re-credentialing information using electronic interfaces with web-based data repositories and primary verification sources, like Council for Affordable Quality Healthcare (CAQH). The repository maintains a history of all provider attestations downloaded and an intuitive viewer provides a side-by-side comparison of select CAQH and CACTUS data.

NetworX Pricer

NetworX Pricer is a java-based application that integrates with our claims system and supports greater contract sophistication, specificity, and processing speed, while eliminating inconsistencies and errors in pricing of providers' claims.

NetworX Modeler

NetworX Modeler helps to forecasts results, negotiate optimized terms, and improve the financial outcome of contracts. It helps to target costly or imprecise contractual provisions before agreements are signed, contributing to improved MLR's.

Provider Portal (NaviNet)

Select Health uses NaviNet as its Provider Portal. Select Health offers access to all the standard transactions through NaviNet including eligibility and benefits, claim status, searchable provider

directory and referral submission and inquiry, as well as links to provider manuals, forms and other important administrative information.

Additionally, and as discussed above in the Medical Management section, multidisciplinary care team member have access to and may benefit from the available feature set below:

- Clinical information delivery including member clinical summaries and alerts for overdue health screens
- Provider report center that offers administrative and clinical reports in print and downloadable formats
- Eligibility/Benefit Inquiry
- Care Gap Alerts
- Claim Status Inquiry
- Claim Correction
- Referral Creation and/or Inquiry
- Authorization Creation, Update or Inquiry
- Clinical Reports and Clinical Alert Reports
- Member Clinical Summary/EPSDT Summary
- Continuity of Care Document
- Searchable Provider Directory. GeoAccess, by Ingenix Suite

HEALTHCARE APPLICATIONS

Facets (TriZetto)

TriZetto's Facets application is an industry-leading software solution for health plan administration. Facets offers a high degree of automation and data capture, achieving fast, accurate claims processing and high auto-adjudication rates. Facets support all data capture and processing associated medical costs. Facets' electronic commerce capabilities are designed to accept and transmit eligibility and claim information in HIPAA-compliant transaction set standard formats.

Data Warehouse

DataStage®, by IBM-Ascential Software Inc. ™, provides an extract, transform, and load (ETL) function to populate business intelligence data into our Data Warehouse. Data are extracted from our business systems databases (such as Facets) and loaded to our Oracle Data Warehouse. This data is then utilized by our reporting programs to support our Enrollment, Eligibility, Encounters, and Claim Payment processes.

Having such a robust and healthy data set is the backbone of Select Health's systems and provides us with the flexibility and resources to build out our current systems to meet any and all infrastructural goals.

2. Identify the essential data elements required to manage day-to-day operations for both CICOs and PCMHs.

As described in question #1 above, Select Health has a robust IT infrastructure that supports our operations and good decision making. To assess the essential data elements for this demonstration project, we need to consider the data elements required to feed the systems described above, the data elements SC DHHS, CMS and any other regulatory agency may request, as well as best in class data to support member coordination through the PCMH.

ESSENTIAL DATA CATEGORIES REQUIRED FOR DEMOSNTRATION

There are a considerable number of data elements required to support the day to day activities of the Demonstration. Below is a list of the overall data categories required for both CICOs and PCMHs to manage the demonstration:

- Clinical Profile
- Riskscore/chronic conditions/gaps in care
- Discharge Information and Summaries from Facilities
- Clinical/Encounter History
- Orders/Labs/Medications/Imaging/Procedures
- Claims and Encounters
- Behavioral Health
- Support Services
- Member Satisfaction
- Membership and eligibility data
- Provider network data
- Care management data, including health assessments, lab results, care gaps, care plans, disease management and case management data
- Utilization data, authorizations, over/under-utilization
- Payments
- Appeals and grievances

Figure 2, below, depicts how all of the above noted data elements integrate together via our enterprise data management architecture. Such data elements are required to meet general business reporting requirements.

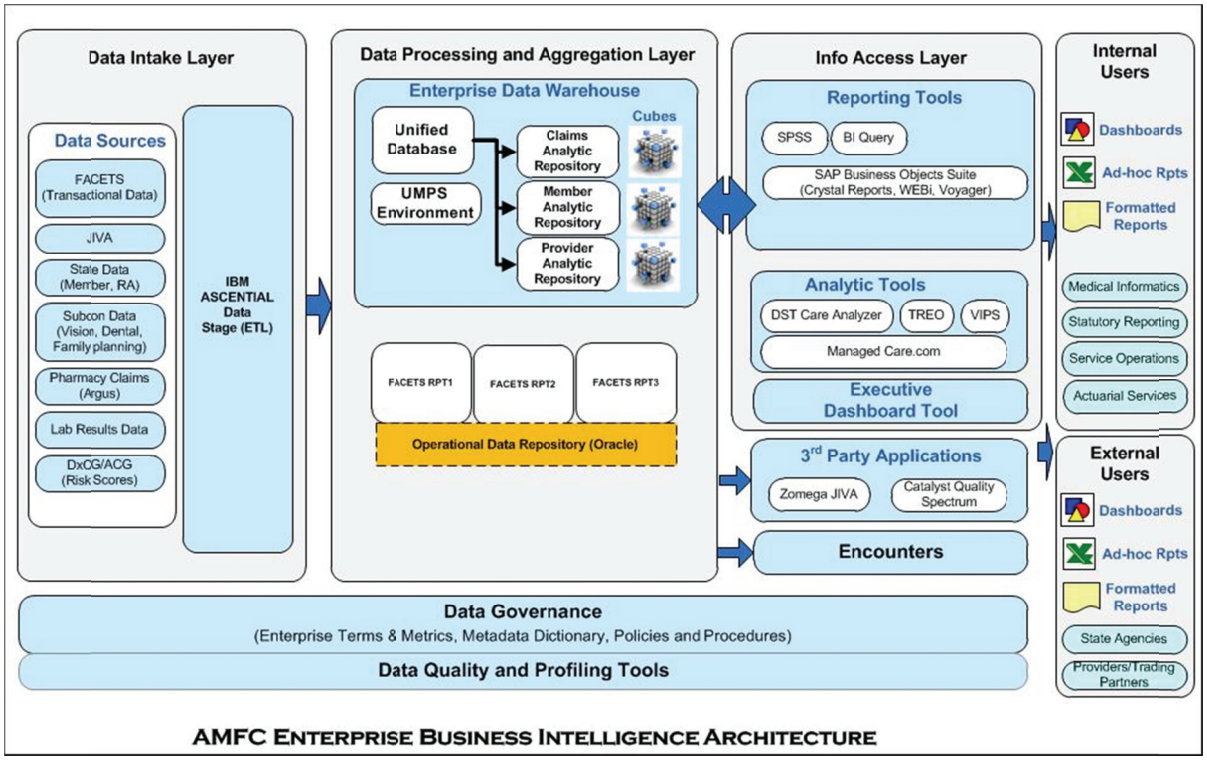

Figure 2: Enterprise Data Management Architecture

III. ADMINISTRATION AND TECHNOLOGY

3. Provide a description of the barriers and/or challenges associated with your organization's ability to successfully comply with any data requirements of the proposed Demonstration. In addition to this description, provide an explanation of: a. The strategies your organization would propose to employ in order to successfully address these barriers and/or challenges; and b. If your organization's proposed strategy involves the establishment and use of data exchanges, please include details about its design, data sources, and application.

Select Health's Information System platform consists of flexible, scalable, and resilient application components designed to successfully manage the complexities of the managed care business. Through our successful implementation and support of Medicaid Managed Care programs in multiple states — Pennsylvania, South Carolina, Indiana, Kentucky, and New Jersey — as well as with CMS and the launch of our Medicare product, we have a proven platform which provides data, application, and reporting services that can easily be configured to project requirements.

Select Health is confident that it will be able to meet all requirements of this book of business. Of course, Select Health must caveat the rest of this response by saying the demonstration has not yet fully defined the data requirements. Such modifications from standard Medicare and Medicaid requirements could create additional administration burden and challenges on Select Health.

Select Health has provided below a summary of what we believe are the most pertinent barriers and/or challenges associated with meeting project requirements.

As discussed in greater detail above, the core functional areas supported by healthcare management systems are:

- **Medical Management**: Intensive Case Management, Utilization Management, Quality Management, Business services for preventative/ESPDT outreach, health risk assessment, case management, service coordination, services for special needs, disease Management, services for managing chronic diseases, etc.
- **Provider Network Management**: Provider Applications, Networx Pricer, Networx Modeler, Quest, TREO Contract Manager. Includes business services to ensure access by distance, cultural competency, specialty, etc.; managing network structure and operations through credentialing, performance management, provider directory management; managing program integrity through fraud and abuse detection, etc.
- **Healthcare Benefits Administration**: Facets-based Applications, Facets Batch Server, Business services for claim and payment processing, eligibility and enrollment.

The services that enable and supplement the core functional areas include:

- **External Portal Services**: Member-facing services for enrollment/PCP selection, preventative outreach and care management; provider-facing services for prior authorization, claims submission, claims status, and clinical summary management.

- **External Web Services**
- **Exchange Services**: Services to exchange data with providers, State and/or its agents;
- **Shared Enterprise Services**: Services for call center management, imaging, faxing; Services for reporting, statistical analysis, data mining, and report distribution, Contact Center.

DATA REQUIREMENT CHALLENGES AND INTERVENTION STRATEGIES

The greatest challenge that we see in meeting program requirements is access to key information. If the data integration from SC DHHS, CMS or providers does not arrive on timely bases or is not accurate and complete, the CICO is at a place of disadvantage in meeting its requirements.

To address the concern, Select Health has historically worked with data providers to program data files to arrive on automated basis. This process tends to decrease human intervention, creating cleaner and timelier data. Additionally, the timely expectation of data allows the CICO to reach out to a data source earlier, should the data not arrive when expected. In some cases, the file transfer was corrupted, and this allowed the supplier the opportunity to quickly address the problem.

Select Health also sees a challenge in the CICOs need to access historical claims data for new members. They will also need access to assessment data and care plan information. Select Health is also of the opinion that this information should follow members as they move from one CICO to another. Ideally, the information will be housed in a centralized location and transmitted upon enrollment.

DATA EXCHANGES

Select Health understands SC DHHS interest in CICO's developing information technology exchanges to support member care coordination. As discussed, Select Health has made significant strides in this arena.

To effectively coordinate and manage member care, Select Health requests that SC DHHS facilitate the timely transfer of participant information (including assessments and care plans) through a centralized database or electronic health record. A common technology platform will facilitate communication across entities and throughout the continuum of care, improving patient safety and reducing the potential for duplication of services or unmet gaps in care.

CICOs and providers must have access to comprehensive and timely information in order to optimize a member's care. As an alternative to each CICO building its own information technology exchange, SC DHHS could coordinate development of a standard platform that can be used by all CICOs and providers.

Data Exchange Architecture

Select Health maintains a suite of fully integrated applications for care management, healthcare benefits management, and provider management. The data exchange is designed to ensure the security of the data, as well as it's the integrity, validity, consistency and timeliness. To ensure that the data maintained within the core applications and databases can be securely and reliably made available to our customer and provider organizations, Select Health has invested in a robust and flexible data exchange architecture, depicted in the Figure 3 below.

Key elements of our e-Health Suite are available in the Continuity of Care Document (CCD) format. The CCD can be integrated with any Health Information Exchange (HIE) that follows current standards. It can also be delivered for direct download to a provider's Electronic Medical Record (EMR)/Electronic Health Record (EHR) through our Provider Portal.

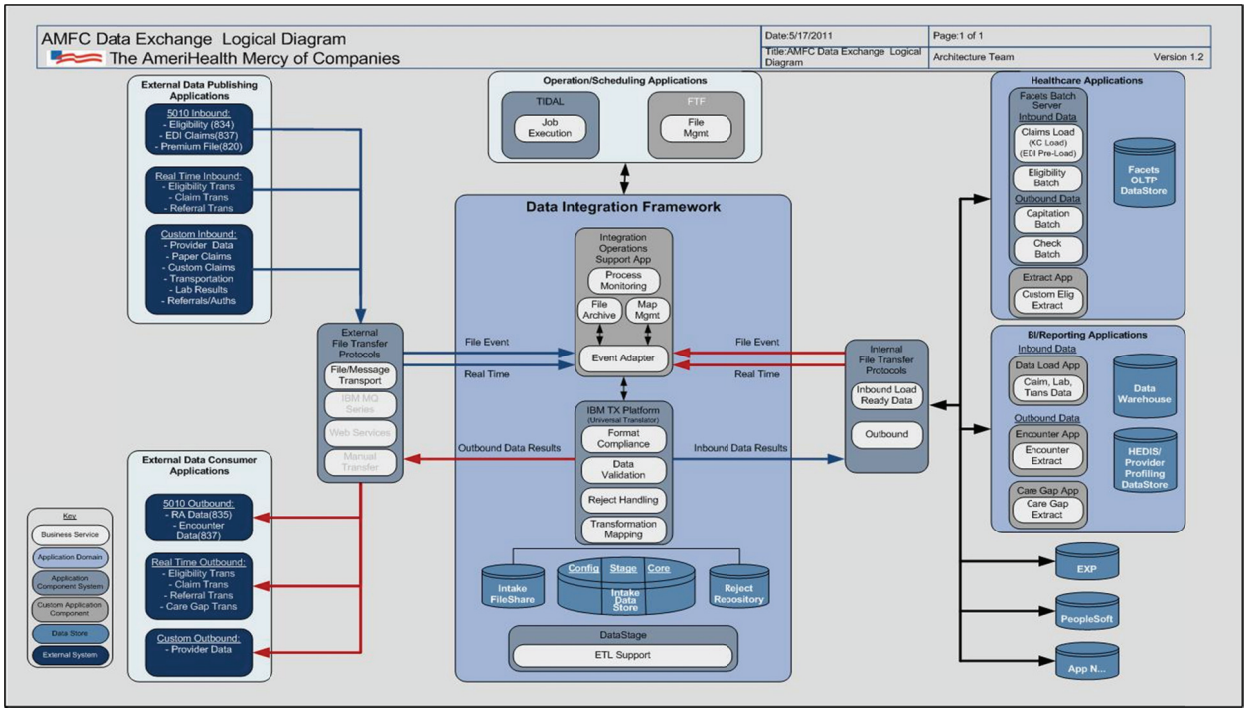

Figure 4: Select Health Data Exchange Architecture

4. Provide a description of your organization's approach to the management of communication between CMS, SC DHHS and your organization throughout the 3-year Demonstration period. Descriptions should consider the following: a. A communication management plan; b. the use, maintenance, storage, exchange and reporting of documents and materials (electronic and print); and c. State (SC DHHS) and federal (CMS) policies, procedures and stipulations.

Select Health feels that good, actionable information drives good decision making. Select Health believes in collecting clean data, through secure means and sharing it with key parties to ensure that all key parities are informed on the best way to care for members, while meeting all state and federal rules and regulations. In the implementation of Medicaid and Medicare plans this year, Select Health has worked with different Departments of Health and Human Services as well as CMS to formalize communication expectations, including data requirements and frequency. The agreed upon communication expectations have then been translated into formal policies and procedures.

OVERVIEW OF COMMUNICATION MANAGEMENT PLAN

Select Health has a standard Communication Matrix document that has historically been developed from the state or CMS issued contract, and finalized through face-to-face communication and interactions. Again, all parties come to these conversations with the best data sharing for the member in mind. And, as noted above, when the Communication Matrix is complete, the requirements are converted into formal policies and procedures.

Select Health's basic communication template contains detail on the scope of work associated with the project and serves as a reference point and guide to all project team members, including CMS and State representatives, throughout the life of the project. The document is updated throughout the project as changes to the project are approved.

The following is a list of the Communication Matrix guiding principles:

- The Communication Matrix will be used on all projects.
- The Communication Matrix will be created in Planning and will identify all project team members, all stakeholders and the type of communication they will receive throughout the life of the project and how often they will receive it.
- The Communication Matrix will also capture the objective of each element of information sharing as well as the means by which the information will be shared (ie., face-to-face, telephonically..etc).
- The Communication Matrix will contain escalation processes and steps.
- The final Communication Matrix will document the ongoing communication requirements between the parties and will be further documented as formal policies and procedures.

DOCUMENTS AND MATERIALS

As discussed in more detail in Question #3 above, Select Health maintains a suite of fully integrated applications for care management, healthcare benefits management, and provider management. The data exchange is designed to ensure the security of the data, as well as it's the integrity, validity, consistency and timeliness. Select Health will work with both SC DHHS and the federal government to ensure that the data exchange meets all state and federal stipulations. To ensure that the data maintained within the core applications and databases can be securely and reliably made available to our customer and provider organizations, Select Health has invested in robust and flexible data exchange architecture.

Key elements of our e-Health Suite are available in the Continuity of Care Document (CCD) format. The CCD can be integrated with any Health Information Exchange (HIE) that follows current standards. It can also be delivered for direct download to a provider's Electronic Medical Record (EMR)/Electronic Health Record (EHR) through our Provider Portal.

In addition to access through our Provider Portal and integration with other HIE, there are numerous options information sharing that can be utilized including secure e-mail, FTP sites and highly customized website utilizing dashboards and specialized document management.

One option we believe would meet the needs of the project is the use of a cloud-based SharePoint site. This would allow management, storage and easy access to project documents by CMS, SC DHHS and Select Health. The robust security model of SharePoint 2010 would enable appropriate sharing of both electronic and paper (scanned) documents across the project partners from document development to publishing. As a cloud-based solution, all project partners would be capable of easily accessing the information with appropriate controls to meet state and federal stipulations and requirements.

The use of SharePoint as an option should be evaluated along with other approaches as more detailed requirements from information sharing are identified in the communications plan. Select Health welcomes the opportunity to keep this an open dialogue and find a solution that meets the needs of all parties.

IV. QUALITY

1. Quality measurement should contribute significantly to managerial and operational decisions. What tools, such as dashboards, would you provide to your network providers to ensure that accurate quality measurement is performed so progress toward specific goals can be attained?

QUALITY DATA AVAILABLE TO PROVIDERS

Select Health offers our providers the full ability to track their performance across multiple metrics, including HEDIS® measures, hospitalizations, ER utilization, etc., through our comprehensive provider profiles. Through our portal, providers can have a 360-degree view of their enrollees with access to clinical information about all of their Select Health enrollees.

Select Health makes an individual Member Clinical Summary available to participating providers for print or download into the provider's electronic medical record via our secure Provider Portal. The Member Clinical Summary is a claim-based medical history including pharmacy and medical management data sets, and any Care Gaps. The Member Clinical Summary is a valuable tool to ensuring appropriate coordination of care.

Every time a PCP accesses our system for an individual enrollee, gaps in that enrollee's care are automatically shared with the provider.

Select Health also creates reports that show providers their performance on HEDIS measures. These reports are based on a rolling 12 months of encounter data and demonstrate a provider's rate of completion, against benchmarks, of applicable HEDIS measure on the provider's assigned membership. The provider completion rates are combined in an overall report card which is shared with the practice. Provider Contracting Representatives use the data to support and encourage high performing practices. In the case of poor performing practices, Provider Contracting Representatives work with these groups to collaboratively develop performance action plans.

E-Health solutions and Technical support

As discussed above, Select Health provides data relevant to patient clinical care management through the provider portals. The system allows qualified providers and staff to access individual enrollee information as well as data for population management.

We also offer support with enrollee notifications so enrollees receive the needed health care services through forms of member outreach including direct mail, member service phone calls and community events.

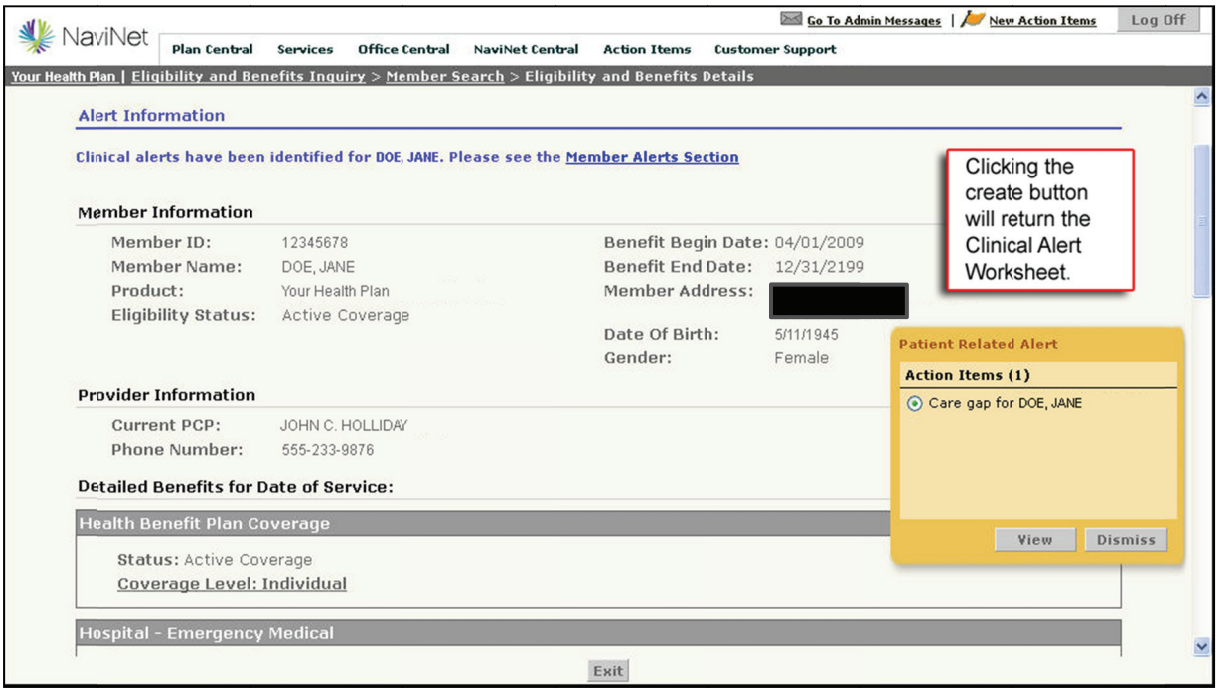

Figure 4: Care Gap Alerts Display on the Provider Portal

Clicking on the alert screen generates a worksheet that identifies the missing or overdue service and the rule used to identify the enrollee as requiring the service. A sample Care Gap Worksheet is displayed below:

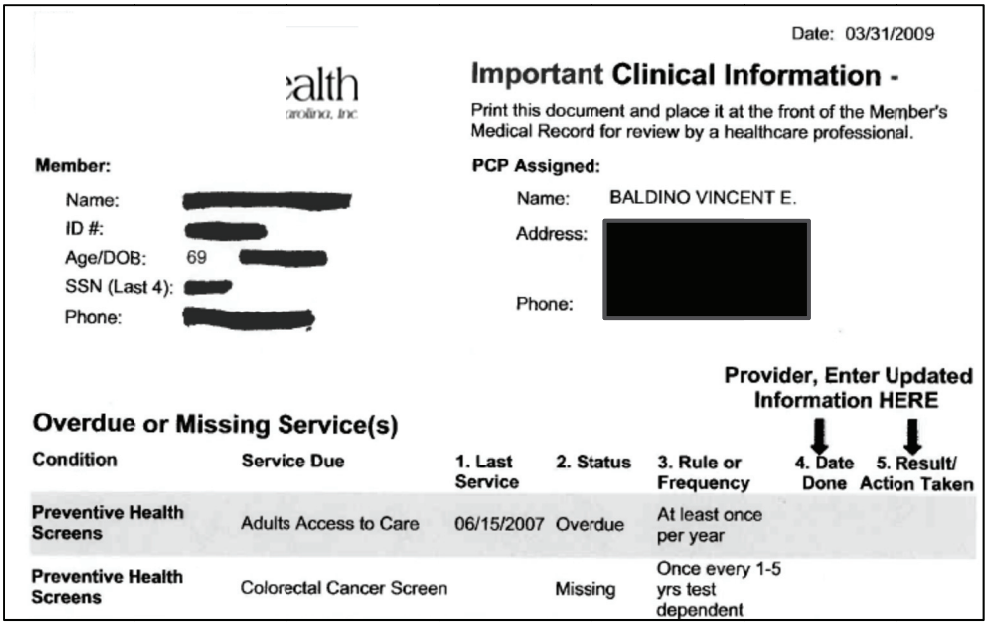

Figure 5: Care Gap Worksheet

Information is also available at the practice level, allowing the provider to use population management techniques within their practice. This panel-level information is available as a printable report or a Comma Separated Value (CSV) file for compatibility with other electronic systems. Providers can choose the age range, conditions and format for the information they want to view.

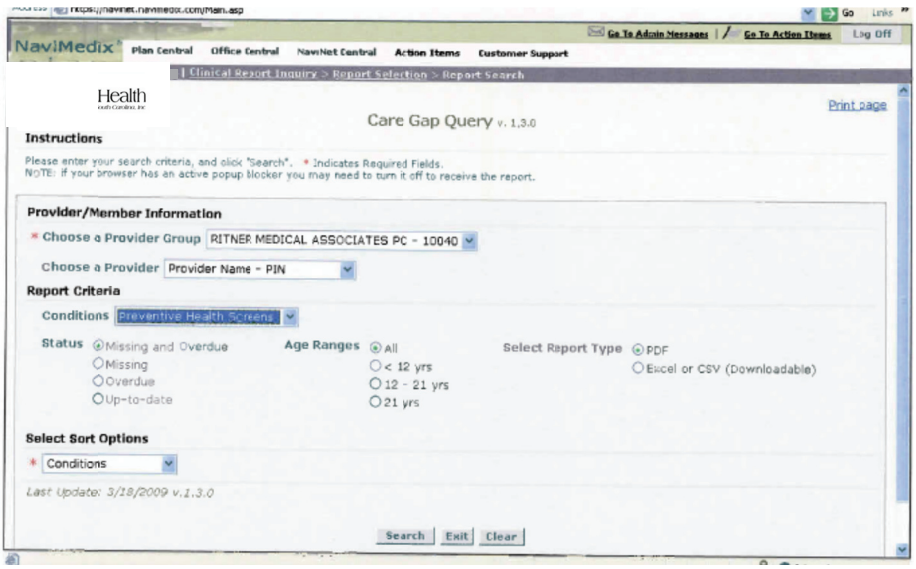

Figure 6: Providers Choose Parameters for Panel Reports

Health
South Carolina, Inc

Member Clinical Summary

Date of Report: 1/26/2010
Member: Mary Jones / 9876543

Member Information
Name: Mary Jones
Address1: 234 Main St
Address2:
City/St/Zip: Chester, PA 19013
Phone: (610) 123-4567
Gender: Female
DOB: 1/3/1980
Member ID: 9876543

PCP Information
Provider Name: Real Care
Address1:
Address2:
City/St/Zip: Chester, PA 19013
Phone:

Medications (within past 6 months)

Fill Date	Name & Strength	Days Supply	Prescriber Name	Pharmacy Name
01/20/10	Acetaminophen – COD #3 Tablet	12	David Yucha	Rite Aid Pharmacy #02548
12/10/09	Naproxen EC 500 MG Tablet	30	Vance J Moss	Neighbor Care Crozer #47037
12/10/09	Prednisolone AC 1% Eye Drop	30	Kevin Stockton	Pathmark Pharmacy #558
10/28/09	Senna Lax Tablet	30	Sharon Wainright	Neighbor Care Crozer #47037
10/28/09	Oxycodone-APAP 5-325 MG Tablet	5	Evan Bash	Pathmark Pharmacy #558
07/31/09	Endocet 5-325MG Tablet	7	David Yucha	Rite Aid Pharmacy #02548

State and federal health privacy laws preclude the inclusion of information related to any behavioral health, HIV-related and/or drug and alcohol addiction medications and treatments in this clinical summary.

Chronic Conditions

Diabetes; Asthma; Coronary Artery Disease

Gaps in Care

Condition	Service	Status	Last Service	Next Service	Rule
Preventive Health Screens	Cervical Cancer Screen	Overdue	11/7/2006		At least once every three years

ER Visits (within past 6 months)

Date	Facility	Reason
09/15/09	Crozer-Chester Med Center	78605 – Shortness of Breath

State and federal health privacy laws preclude the inclusion of information related to any behavioral health, HIV-related and/or drug and alcohol addiction medications and treatments in this clinical summary.

Inpatient Admissions (within past 12 months)

From Date	To Date	Facility	Reason

There are no data records available for this section.

Office Visits (within past 12 months)

Date	Provider	Specialty	Reason
12/22/09	David Yucha	Orthopedic	71947 – Pain in Joint, Ankle and Foot
12/08/09	Kevin Stockton	Orthopedic	71537 – Loc Osteoarthoros Not Spec Prim/sec Ank&Foot
12/14/09	Sharon Wainright	Orthopedic	71517 – Primary Localized Osteroarthrosis Ankle and Foot
10/07/09	Evan Bash	Orthopedic	71947 – Pain in Joint, Ankle and Foot
09/24/09	Bruce Johnson		
05/27/09	David Yucha	Ophthalmology	36410 – Unspecified Chronic Iridocyclitis

State and federal health privacy laws preclude the inclusion of information related to any behavioral health, HIV-related and/or drug and alcohol addiction medications and treatments in this clinical summary.

Figure 7: Sample Enrollee Clinical Summary

2. Evaluation is an essential component to the Demonstration from the State and Federal perspective. Describe the methods you would use to incorporate quality measurement into the evaluation process of the Demonstration.

Select Health recognizes that the Quality Assessment/Performance Improvement Program (QAPI) is critical to all aspects of clinical care and service. We would encourage SC DHHS to use quality measurement to evaluate the Demonstration. Select Health has a strong history of partnering with SC DHHS to customize QAPI program offerings to support specific quality goals and program evaluation.

Select Health's QAPI Program adheres to the program structure requirements mandated by NCQA. Our QAPI program integrates knowledge, structure, and processes throughout the health care delivery system to assess risk and to improve quality and safety of clinical care and services provided to enrollees. The QAPI program provides the infrastructure to systematically monitor, objectively evaluate, and ultimately improve the quality, appropriateness, efficiency, effectiveness, and safety of the care and service provided to members.

Physician engagement is critical to success of Select Health's QAPI program. Community physicians participate on all clinical committees and sub-committees, making decisions on policy direction. These physicians then support the QAPI directly through their own practices and indirectly by responding to questions raised by other physicians.

Select Health would use this infrastructure and process to assess the impact on the demonstration population. The QAPI already includes robust policies and procedures that outline key functions and standards. Select Health would welcome the conversation with SC DHHS around baseline population data and factors to monitor through the demonstration. Results can be rolled into corrective action plans and performance improvement initiatives throughout the demonstration period to improve performance for targeted service and clinical outcomes.

The established QAPI Program involves resources and leaders from all areas within Select Health. QAPI goals and initiatives are incorporated into department goals and individual staff goal planners to ensure visibility and appropriate attention to QAPI Program execution. Of course, this would also allow Select Health to monitor the demonstration success and change course as needed.

SELECTING AREAS OF FOCUS

Historically, the areas targeted for improvement projects are based on an assessment of current performance and of the greatest impact on enrollee outcomes and health status. Areas for focus are identified and prioritized according to their ability to meet the following criteria:

- Clinical importance and scientific validity
- High-risk and/or high-volume service or process
- Relevance to the population

- Alignment with State priorities

In partnering with SC DHHS on this demonstration, we would actively seek opportunities to improve the quality of care and services we provide to our demonstration enrollees and providers and, again, working together to ensure we are monitoring key metrics.

PROCESS FOR EVALUATION

Progress toward QAPI goals and performance on key measures is monitored throughout the year through updates to the QAPI work plan. A full evaluation of program results, including overall effectiveness and demonstrated improvement, occurs annually by committees consisting of key organizational leaders and committee physicians.

The Select Health management team oversees this process by reviewing and analyzing the key performance monitoring data to evaluate internal and subcontractor performance. The management team provides multidisciplinary oversight and peer-to-peer support for each departmental manager.

After internal department review, results are reported. Select Health would also welcome the chance to work with SC DHHS at these steps to ensure that PIPs and subsequent periods of monitoring are agreed upon and redirected, as needed.

ANNUAL EVALUATION

In keeping with our tested processes, a comprehensive evaluation of the QAPI Program is completed annually (and as needed) to measure its effectiveness. The annual QAPI program evaluation will include an assessment of progress toward the annual goals outlined at the start of the program year. Results for each goal are documented, along with an overview of barriers and interventions implemented during the year. Results are analyzed to indicate whether or not the goal was met, with drill-down analysis conducted to understand the drivers of the results.

For findings that do not meet organizational goals or the goals of SC DHHS, an analysis is completed with the organizational staff and committee physicians so that potential barriers can be addressed. This thorough analysis includes additional data to assist in the identification of opportunities for improvement.

The comprehensive evaluation includes recommendations for improvement in the QAPI Program, proposes goals and objectives for the following year, and identifies the resources necessary to accomplish the proposed goals and objectives. The QAPI evaluation is used to determine the QAPI program description and work plan revisions for the following year and to then continue tracking the ongoing success of the demonstration.

3. What strategies will you use to share provider performance with enrolled Beneficiaries and others?

Select Health believes that sharing provider performance data with members, along with compelling incentives, can drive behavioral changes that create a more efficient and higher quality system of care. As such, Select Health has invested heavily in providing data to members through telephonic outreach, mail campaigns, health education materials, community outreach programs, online supports and many other various avenues. Any combination of these methods, described in further detail below, may be utilized to share provider information with beneficiaries.

MEMBER PORTAL

The objective of the Member Portal is to provide members with efficient and secure interactive tools to help them develop a clear picture of their medical care, which includes actionable data to help in selecting the provider who best fits their needs. By giving members access to such information, clinical outcomes improve through better medication adherence and a reduction in care gaps.

The portal already allows members and guardians to establish a user ID and password for secure access to personal information and assistance in a number of categories, but plans are in place to allow access to provider quality information as well.

Currently, in our Pennsylvania market, we are working toward a Member Portal upgrade that would allow members to view and compare specific procedure costs at hospitals and outpatient facilities. Physician cost and quality transparency data will ultimately be available through this same member portal.

Such analytics could be similar to the web page that the member now views when selecting a primary care provider (PCP). When a member completes this process, he or she first enters the zip code, and the system filters the data by location. The member can able enter a number of selections including physician gender, language and specialty. The system then filters the data by these selections and provides the member with the respective matches.

In this future state, when a member is selecting a PCP, they could also be prompted to select a high-efficiency provider, as defined by average cost of procedure or visit and quality performance. The member could also be prompted to select a provider with the highest Healthcare Effectiveness Data and Information Set (HEDIS®) adherence rates. Furthermore, when a member is prompted to follow-up on a care gap, they could also be prompted to use a number of cost- and quality-related filters. For example, should a member need a procedure, they could search for the providers and locations with the highest quality, as measured by health outcomes.

SHARING PROVIDER PERFORMANCE DATA THROUGH CALL CENTER SUPPORT

Should a member call into our call center, the Member Services representative could guide the member through this selection process verbally. As discussed above, the representative would be alerted to the potential need for services by the member's ID and simply direct the member through the analytic process to aid in his/her selection of the appropriate care location and provider.

SHARING PROVIDER PERFORMANCE DATA THROUGH EOB STATEMENTS

Cost and quality transparency data will also be made available to the member in the explanation of benefits (EOB) statement and the member's landing page on the Member Portal. The EOB explains what medical treatments and services were reimbursed on the member's behalf, describing: the service performed (including the date and description of the service, as well as the name and location of the service provider); the provider's fee and the MCO's contribution and the amount for which the patient is responsible, if any, and directions for filing an appeal. The member's landing page on the Member Portal will contain the same information in an electronic format.

SHARING PROVIDER PERFORMANCE DATA THROUGH COMMUNITY PARTNERSHIPS

Cost transparency data can also be made available to all community support and member activist organizations. These organizations serve to support members and direct them to the best care available. Although their expertise and knowledge would still drive their advice and recommendations, the availability of such data could serve to inform their opinions and hopefully better connect the member with the most efficient and highest quality provider.

TIMELINE

The greatest limiting factor in providing members access to such cost transparency data is defining the data definitions. Select Health would look to partner with SC DHHS on setting these definitions, so that when communicating to a member or community organization that a certain PCP is a high-quality provider, all parties are in agreement as to the precise definition.

MEMBER INCENTIVES

Select Health has a history of successfully leveraging actionable information with member incentives to change behavior. Information concerning incentives can be communicated through the Member Handbook and Member Portal, as well as member materials. Additionally, Select health conducts targeted communication campaigns (electronic, text, telephone, mail) to the population to inform them of the benefit.

All member incentives would also be in accordance with all local, state, and federal laws and with the approval of SC DHHS. Potential incented behaviors could be:

- Selection of a provider or care location from the Member Portal or via a telephonic interaction with a Member Services representative verbally guiding them through the process
- Completion of more than 80 percent of care interactions with high-quality providers, as defined by Select Health
- Upon completion of a procedure at a high quality and preferred location, as defined by Select Health

The definitions of these settings and their correlation to quality would need to be well-defined and supported. The priority is always in directing members to the most efficient and highest quality care resources available.

4. Has your organization and/or parent company participated in any quality improvement initiatives that address the Dual Eligible population? Please explain and include details of the evaluation and the outcomes of the initiative.

Although Select Health will not start serving a formally defined Dual population until January 1, 2013 with the launch of our Dual Special Need Plans, we are not unfamiliar with the dual population.

Until 2006, our Pennsylvania Plan had dual eligibles enrolled in a Medicaid plan for the management of the Medicaid portion of their benefits. We have also served the Aged, Blind and Disabled (ABD) population for over 30 years. A good proportion of the ABD population is, in fact, dual eligible. We have implemented a number of quality improvement initiatives with this ABD population around utilization patterns as well as disease management with wonderful results.

Select Health has a strong history of performing quality program evaluations and using the results to drive improvement in our health plans. We evaluate our results against internal and external program goals. Multiple data sources are used for the evaluation, including, but not limited to, utilization, clinical outcomes, satisfaction, and process metrics. Results of the evaluation are used to guide program goals and changes for the next measurement period. The quality improvement process and example outlined below is specific to this ABD population – predominantly made up of dual eligible members.

Table 2: Example of Successful Performance Improvement Plan

Select Health Affiliated Plan – Central Pennsylvania Aged, Blind and Disabled Population		
Topic	Improving the Management of Diabetes in the Latino population through screening measures	Type: Clinical
Relevance	Diabetes is a significant national issue, especially among the Latino population.	
Baseline Data	2006 Calendar Year results as measured through HEDIS 2007	
Goal	Achieve the 90th NCQA percentile for each measure.	
Benchmark	NCQA 90th Percentile	
Barriers	• Enrollee knowledge deficit of the long-term effects of diabetes. • Transportation is a barrier against obtaining preventive health services. • Availability of healthy and culturally relevant diet options.	

Select Health Affiliated Plan – Central Pennsylvania Aged, Blind and Disabled Population	
	• Fear of needles; fear of pain.
Interventions	• Community Outreach Events at multiple sites/counties by community outreach staff • Implemented changes in the New Enrollee Portal with various educational topics in Spanish and English. • Provided PCPs Care Gaps via provider portal • Case management outreach calls to coordinate provider visits and laboratory testing and pharmacy needs. • Pharmacy mailing to the enrollees regarding medication adherence, lipid and HgbA1c testing and to those with high HgbA1c results.
Results	Consistent improvements in diabetes care for entire program measurement period including statistically significant increase in HbA1c testing and LDL-C screenings, and close to 30% more diabetic members with HbA1c under control.

5. Describe your organization's experience with CAHPS. How would you envision your organization's use of CAHPS as a component of the SCDuE Demonstration's quality improvement?

Select Health conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys of our enrollees on an annual basis using an NCQA-certified vendor. CAHPS surveys are used to assess the patient-centeredness of care, compare and report on performance, and improve quality of care. We routinely conduct both the Adult and Child CAHPS survey. We report the results of each survey separately to SC DHHS, providers and members annually.

Survey results are analyzed and compared against NCQA and AHRQ benchmarks, our plan goals, and other plans nationally. For findings that do not meet organizational goals, we complete an analysis to identify and address potential barriers. This thorough analysis includes drawing upon additional data to assist in the identification of improvement opportunities. A wide variety of information, such as enrollee complaint/grievance data and enrollee disenrollment data, is included in the analysis. We include participating community providers in discussions to identify improvement opportunities.

CAHPS can also be utilized to monitor and evaluate PCP compliance with availability and scheduling requirements. When select (CAHPS) responses are combined with the results of our ongoing PCP monitoring activities, and Select Health phone access performance evaluations, we are able to create a global picture of provider appointment access and geographic availability. The findings are reported and, as appropriate, corrective action plans are recommended and monitored to make certain the providers are meeting Plan standards.

6. Describe the quality measures your organization currently utilizes.

Select Health believes that good, actionable data drives good decision making. Areas targeted for improvement projects are based on an assessment of current performance and are prioritized in relation to which will have the greatest impact on enrollee outcomes and health status.

Performance goals and benchmarks are identified based on performance targets, industry trends, state experience, and quality committee recommendations. Creation of benchmarks and goals include consideration of, but are not limited to, data from the following data sources:

- HEDIS/CHIPRA
- CAHPS [Adult and Child versions]
- AHRQ Prevention Quality Indicators (PQIs)
- State data
- Provider satisfaction surveys
- Enrollee disenrollment surveys
- Utilization data
- Enrollee satisfaction data
- Access and availability data
- Internal service data
- Delegate subcontractor reports

Every effort is made to collect and use timely, complete, and accurate data. Data used for evaluating performance include, but are not limited to:

- Access and availability data
- Claim data
- Clinical guideline performance studies
- Cultural and Linguistically Appropriate Service data
- Focused reviews
- Health Risk Assessment and Screening responses
- HEDIS and CHIPRA data

- Enrollee satisfaction data
- Enrollee opt-out data
- Medical record reviews
- PIP/outcome study analysis
- Pharmacy utilization data
- Provider and participant satisfaction survey results
- Physician office medical record reviews
- Quality indicator studies
- Sentinel condition analysis
- Utilization date

Select Health incorporates internal performance targets, standards, and external benchmarks into our internal key indicator monitoring and reporting, as we work with SC DHHS and provider partners to identify areas for additional analysis and, as necessary, implementation of quality improvement activities, and corrective actions.

Each functional area of Select Health is responsible for reviewing and analyzing data findings and quality activities within the department. Included in the analysis, as applicable, are the following:

- Actual performance compared with established performance goals and thresholds
- Data trends
- Actions taken that positively impacted outcomes and action plans
- Resources and responsible persons to achieve desired result for measures not meeting expectations

The Quality Assessment and Performance Improvement committee and its subcommittees are responsible for reviewing and analyzing key performance monitoring data to evaluate internal and subcontractor performance and quality improvement activities. Our quality committees provide:

- Multidisciplinary oversight of key clinical and service performance indicators
- Coordination and integration of clinical and service improvement into organizational Quality Improvement activities
- Monitoring of targeted performance against actual performance
- Identification of areas of improvement based on review of data

- Implemention and/or oversight actions needed to achieve clinical, service and organizational objectives

- Monitoring of the effectiveness of action plans

These key performance indicators are collected and reported to the appropriate quality committee. This upward reporting provides ongoing feedback to each department on key performance indicators and assists us in identifying opportunities for performance improvement.

As part of the planning process, we form a workgroup consisting of representation from stakeholders and subject matter experts. The workgroup conducts additional analysis using techniques appropriate to the identified opportunity.

IV. QUALITY

7. Describe the quality measures your organization would utilize as a CICO. Responses should include quality measures that focus on acute and primary care, behavioral health care, community support services, care management and/or transitions or other relevant measures (include any relevant Medicare Advantage and HEDIS measures).

As discussed in detail in question #2, Select Health recognizes quality assessment and resulting performance improvement projects to be critical to all aspects of clinical care and service as well as in assessing the success of the demonstration. As discussed in question #6, there are a significant number of quality measures we currently utilize and would continue to use as a CICO. We will collect data, evaluate and take appropriate action on the full spectrum of HEDIS® measures, utilization rates and STAR measures, including tools such as Consumer Assessment of Healthcare and Provider Satisfaction (CAHPS), and Hospital Outcome Survey (HOS). Select Health also has significant experience bringing new Consumer/Family Satisfaction Teams (CFST) and their survey process into new areas. Results of CFST surveys are leveraged as a core element of the overall quality management program.

In addition, we have numerous evidence-based metrics that we follow, including, but not limited to:

- Appropriate medications for members with heart failure (medications that are indicated as well as those that are not)
- Medication regimen and glycemic control for members with diabetes
- Oral steroid use and controller medications for members with COPD and asthma
- Glycemic and lipid monitoring for members on antipsychotic medications

We will monitor metrics around care transitions, including but not limited to:

- Percent of transitions with a complete medication reconciliation
- Percent of members seeing their PCP or treating physician within five days of an ER visit
- Percent of members referred for behavioral health services who receive a behavioral health intervention

We will monitor metrics around community supports, including but not limited to:

- Percent of members assessed for community resource needs
- Percent of members with needs connected to care
- Adverse event rates (ER/1000, Inpatient/1000) for members receiving in-home support services

We will monitor separate sub-population metrics (adverse event rates, well care rates, diabetes, cardiovascular disease and pulmonary disease condition metrics) for members with special needs, including but not limited to:

- Members with a serious mental illness (SMI) diagnosis
- Members receiving in-home support care
- Members living in a residential facility (assisted living, group home, nursing facility)

We will also monitor our provider network access and availability, including but not limited to:

- The numbers and types of contracted providers
- The number of network providers who are not accepting new patients
- The geographic location of providers and members, considering distance, travel time and commonly used means of transportation and provisions for physical access for members with special health care needs
- Provider care quality including their rate of care gap closures, re-admissions as well as HEDIS® rates
- Provider appointment access
- Provider-to-member ratios

V. TIMELINES

1. Given the Demonstration's timetable for operations, outlined in the Background section above, how long will it take you to build a comprehensive statewide Network to serve this Demonstration's target population?

Given Select Health's current Medicaid network and its Medicare network scheduled to go-live with the dual-SNP plan in January 2013, Select Health is uniquely positioned to leverage its existing networks in order to support the demonstration population. Select Health is confident it would be ready to support the SC DHHS' enrollment and go-live dates.

Select Health's experience with building provider networks for 16 years makes it uniquely qualified to build an expansive provider network to meet the expanded needs of the dual demonstration and to meet network and access requirements, as they become more defined. Our Network Management Representatives live and work across South Carolina, developing face-to-face relationships with providers state-wide.

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are key safety-net providers in South Carolina serving the rural and underserved populations. Select Health has developed close relationships over the past ten years with South Carolina Primary Health Care Association (SCPHCA) and South Carolina Office of Rural Health (SCORH). Select Health has partnered with these associations at the state level to sponsor educational training and workshops for the community health centers and will continue work with the local centers to:

- Participate in workgroups to assist in development and growth opportunities
- Implementation of electronic health records
- Provide education to residents on collaborative efforts established by the health centers
- Improving overall health of residents by sponsoring health fairs

Access and education for Medicare and Medicaid recipients are key to improving their health and Select Health will continue to partner with SC DHHS and local leaders of these centers.

Select Health is aware of SC DHHS goal to enroll members beginning in October 2013 with a service go-live of January 2014 for Region 1 and with Region 2 following. Although Select Health believes these dates are achievable goals, SC DHHS will need to finalize contract requirements as soon as possible, as we are not able to begin reconstructing and filling gaps until that is complete. Further, Select Health would urge SC DHHS to follow the dual-SNP contracting requirements and timeline and to not require a complete network at the time of the RFP.

Select Health has a robust existing network; however, some services and geographic gaps would need to be filled. To meet the network gaps, we have developed a proven process to ensure we can quickly build a complete provider network. Our plan for network development is based on the following critical elements:

- The anticipated enrollment and expected utilization of services, considering the characteristics and health care needs of the population
- The numbers and types of providers required to meet the needs of the population
- The number of network providers who are not accepting new Medicaid patients
- The geographic location of providers and members, considering distance, travel time and commonly used means of transportation and provisions for physical access for members with special health care needs

V. TIMELINES

2. What is the timeframe necessary to design and deploy Multidisciplinary Teams and the operational infrastructure to support these Teams?

Multidisciplinary teams and the operational infrastructure to support these teams are paramount for Select Health of South Carolina to effectively operate a quality improvement and medical management program or to successfully manage the specific health care needs of the demonstration population. Select Health will develop and execute care plans that not only manage members' health, but also proactively provide early screenings. The ability to adequately develop a strong model of care to manage and enhance members' quality of care will make this demonstration successful.

MULTIDISCIPLINARY TEAMS

Select Health's dual-SNP will go live January 2013 with our complete and CMS-approved model of care, including our Integrated Care Teams. Our recent experience of building these teams uniquely qualifies us to expand these services to a different population and broader geography. The team structure will also need to be strategically expanded to coordinate with the HCBS waiver care manager.

Given Select Health's current Medicaid multidisciplinary teams and the D-SNP going live January 2013, Select Health is uniquely positioned to leverage its existing infrastructure to support the demonstration population.

Select Health is aware of the South Carolina Department of Health and Human Services' (SC DHHS') goal to enroll members beginning in October 2013 with a service go-live of January 2014 for Region 1 and with Region 2 following. Although Select Health believes these dates are achievable goals, SC DHHS will need to finalize contract requirements as soon as possible, as Select Health is not able to begin reconstructing and filling gaps in the network until that is complete. This is an inhibiting factor to the development of enough PCMH to support the complete population.

Select Health is prepared to contract and provide PCMH providers enhanced reimbursement for member management, as justified by enrollment. Assessing enrollment concentrations by PCMH will be a final stage in culminating these teams.

OPERATIONAL INFRASTRUCTURE

Select Health will document all data collection and analysis, actions taken to improve the performance of the model of care and the participation of the interdisciplinary team members and network providers in quality improvement activities.

Communication and data exchange between key parties is a key element of our model of care and empowers the integrated care team to be effective. Furthermore, quality improvement activities need to be coordinated with other performance monitoring activities and management functions. This will include, but is not limited to, utilization management, case and disease management,

health management, behavioral health management, risk management, patient safety, cultural competency, credentialing, claims, member and provider services and network development.

As the member and members of the care team are rarely in the same location, a robust data system had to be developed to allow for data capture and communication.

To meet these needs, a data system has been developed. Staffing and training is occurring over summer 2012, in preparation for the January 2013 D-SNP go-live. It is reasonable to assume that upgrades and build outs of this system could occur for the follow year's demonstration enrollment period.

V. TIMELINES

3. Please identify any potential disruptions the Demonstration's time line along with potential remedies?

Select Health is supportive of the Demonstration and the potential impact that may be made on the Demonstration population. However, new programs carry with them potential disruptions. Although these potential disruptions cannot be eliminated, mitigation strategies may be able to keep the project moving forward. Below, please find a summary of Select Health identified potential disruptions along with potential remedies.

Potential Demonstration Disruption	Mitigation Strategy
CMS Approval Process. ACA obligations, specifically Exchanges, could limit CMS' interest in broad Demonstration projects or postpone projects. Additionally, CMS may limit the number of dual eligible enrolled in the demonstration and limit by category. Lastly, CMS may not approve all aspects of SC DHHS current proposal.	Partner with local care providers and jointly communicate with CMS
Regulatory and Legislative Risks. CMS is required to draft detailed regulations for the actual implementation of ACA, in a process that could heavily politicized and impact CMS' ability to host multiple demonstrations.	Participate in legislative process. Participate in processes with executive branch to mitigate negative risks.
Assuring effective procurement approach. Managed Care is very competitive. An RFP process can bring new and unknown players to the market that are not able to meet the needs of the demonstration. These new entrants may drive up contracting rates to gain a foothold.	Conduct and thorough and thoughtful RFP process, potentially limiting proposals to known and licensed incumbents.

Demonstration Rates. Demonstration rates that do not meet the needs of this population may cause CICOs to not take interest in the proposal or may not make the project viable long term.	Develop stratified rate categories which reflect expected variation in membership . Utilize the final SGR (RBRVS update), rather than the estimated SGR included in the published Medicare standardized FFS county rates, in the Medicare Fee for Service baseline. Include an allocation of CMS expense related to bad debt for this membership in the Medicare Fee for Service baseline. Provide for the full range of benefits and appropriate incentives. Ensure transparency of rate development process. Fully demonstrate all assumptions and adjustments made to baseline data during the rate development process. Include an adequate provision for administrative expenses. Consider expanding the quality bonus payment beyond a withhold to include an incentive payment based on star ratings similar to the Medicare Advantage program.
Patient and Provider Data. Defining clear data definitions on quality and service outcomes on members and providers will be key in assessing success and ensuring coordination of members across CICOs.	SC DHHS should take the lead in creating data definitions SC DHHS should also take the lead in creating a central data repository to support data sharing between CICOs.
Providers' resistance to contracting for Demonstration services. Providers are questioning if they can afford to work with different Medicaid and Medicare populations. This can impact CICOs ability to build adequate networks in certain areas.	Create flexible PCMH medical home reimbursement strategies to allow CICOs to pay for high quality care. Transform traditional reimbursement models to transparent models, aligning incentives between payer and provider.

Figure 8: Potential Demonstration Disruptions and Mitigation Strategies

VI. CARE COORDINATION

1. Given the demographics and health status of the Dual Eligible population in South Carolina, describe and discuss the model of care coordination you believe will be most successful in meeting their needs.

Based on the data provided in Appendices C, D and E, the target population exhibits a high incidence of significant cardiovascular disease (24.4 percent), diabetes (16.7 percent), renal disease (15.6 percent), pulmonary disease (10.7 percent), metabolic disorders (10.2 percent) and psychiatric conditions (9.5 percent). In addition, 45 percent have some impairment in their ability to perform activities of daily living. Between 13 and 17 percent (depending on the age bracket) of their encounters with physicians occur in the emergency room.

To address the needs of this population, Select Health recommends a model of care that focuses on improving health outcomes for the population through coordination of services using an identified point of contact with timely access to essential services. The model needs to effectively corral physical health, behavioral health, pharmacy and community-based services into a cohesive web of service that is individual to each member. The following four elements are key to implementing this model:

- **Data-drive interventions** – The model needs to incorporate analysis of all available data to identify members with impactable conditions, risk for future avoidable episodes of care and likelihood of future inpatient admission. In addition to this predictive data modeling, the model should use data to guide outreach and education on specific evidence based guidelines relevant to the population, including chronic condition management, medication management and primary and secondary prevention.

- **Member engagement** – Proven strategies to connect with members where they live and around the problems and issues that are facing them beyond their health care. The social and environmental issues faced by this membership are as much drivers of their health outcomes as their knowledge of their clinical condition.

- **Provider Engagement** – Programs to actively involve providers in improving health outcomes are essential for the model's success. In addition to payment methodologies that reward performance, the model needs to have transparent and reliable data-sharing and communication programs to ensure that everyone involved in the member's care has the same information.

- **Care Integration** – To truly succeed in meeting the needs of this population, the model needs to function seamlessly across all of the care silos and settings, from behavioral health to acute inpatient care to outpatient pharmacy. Programs carving out segments to vendors will not be able to deliver the comprehensive web of services necessary to support these complex members.

VI. CARE COORDINATION

2. Provide a description of your organization's management structure to support the delivery of a full continuum of Medicare and Medicaid services through the Multidisciplinary Team (that will be led by the CICO/PCMH Care Coordinator).

Given Select Health of South Carolina's extensive history in the South Carolina market, and its Dual Special Needs Plan set to go-live January 1, 2013, Select Health is well positioned to expand its management structure to include the demonstration.

The management structure includes centralized administrative, operational and compliance functions while decentralizing the member and provider focused services into the market. This allows the business president to report directly to the CEO while still giving the business president control at the market level. The CEO reports directly to the board of directors.

Many functions will be clearly distinct for the demonstration membership, such as enrollment. Where appropriate, however, many resources will be shared across product lines. One example of such functions is Provider Network Management. Lastly, areas such as Marketing and Medical Management will be operated as a blend of shared and distinct in order to leverage existing best practices while giving flexibility to the local needs of the membership. All key functions will be led by a minimum of a director level position that will report to the business president.

An important component of the organizational structure will be the establishment of routine oversight. A regularly scheduled steering committee will be developed consisting of all key personnel to provide an avenue for these discussions.

The model of care is supported by a variety of staff across the organization including those in administrative roles, clinical roles and those in oversight roles. These individuals provide key functions that create the Interdisciplinary Care Team (ICT). The ICT is a group of professionals, paraprofessionals and non-professionals who possess the knowledge, skill and expertise necessary to accurately identify the comprehensive array of the beneficiary's needs, identify appropriate services and design specialized programs responsive to those needs. These functions will all have accountability to department directors at the local level and will have additional oversight through the business president.

The composition of the ICT varies according to the beneficiary's individual care needs. In addition to the beneficiary and/or caregiver, ICT members may include health plan physicians, nurses, social workers and pharmacists, the beneficiary's primary care physician (PCP), specialists and ancillary providers involved in the beneficiary's treatment and community resource staff. In focusing on the demonstration population, this ICT will also include the HCBS care manager.

VI. CARE COORDINATION

3. What are the most important skills of the Multidisciplinary Care Team?

As discussed in question #1 within this section, it is imperative that a member's care plan coordinates services using an identified point of contact with timely access to essential services. The model needs to effectively corral physical health, behavioral health, pharmacy and community-based services into a cohesive web of service that is individual to each member. This will only be successful with a talented multidisciplinary care team.

Select Health believes that the most important skills of the care team are: working from a knowledgeable base of health coaching, a great deal of empathy as well as the ability to be an excellent listener and translate what is heard into an actionable and flexible care plan.

When dealing with a population as complicated as dual eligibles, there is not a single care plan that will work for all members. To that end, the care team needs to be knowledgeable on what tools and resources are available to a member. If the member has certain barriers to care – such as transportation – the care team needs to be savvy enough to connect the member to an appropriate resource.

The care team also needs to be empathetic. Communicating with members and understanding what challenges they are dealing with can help a care team assess what help a member really needs. For example, having empathy for a member's fear in testing his blood glucose can change the conversation from one of member's noncompliance to a conversation around ways of testing that the member may not fear as much.

Additionally, it is always important to listen to members and understand their concerns and needs. Beyond being empathetic of what they share, it is important to hear what they are saying and connect them to the appropriate resources. Again, sticking with our example from above, if a member is not testing his blood glucose because of fear, we need to hear that concern – specifically – and not assume that he does not, for example, know how to complete the test or does not want to complete the test. We need to hear that it is a fear issue and address the concern. In that same vein, the listening of the care team needs to translate to an appropriate action within the care plan. So, does this member need a new glucometer that tests in a different location or does he need a home visit to help him get comfortable with his glucometer?

A care team that is able to work from a knowledgeable base of health coaching, has a great deal of empathy, listens and translates what is heard into an actionable and flexible care plan can have a dramatically positive impact on the members they work with.

VI. CARE COORDINATION

4. What types of medical, behavioral health, HCBS, and other services and strategies are most likely to be successful in averting: a) preventable emergency room visits, and b) preventable acute inpatient admissions and readmissions?

Effectively managing avoidable emergency room visits, hospital admissions and readmissions requires moving from a reactive, episodic health care system to a proactive model that promotes care coordination and evidence-based medicine through information sharing.

Our approach requires us to establish a true medical home for members and align provider reimbursement with desired health outcomes. These tools also allow us to follow a comprehensive chronic care model to address the needs of members with chronic illness. Our experience has shown that such measures, in combination with appropriate care management for those with chronic conditions, drive substantial reductions in inappropriate ER use and subsequent admissions and readmissions.

OVERVIEW OF SERVICES AND STRATEGIES

Our Integrated Care Management model blends traditional disease management with complex case management. We offer programs for the following chronic health conditions that if left unmanaged, result in poor health outcomes and high rates of hospitalization: diabetes, asthma, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure, HIV, sickle cell disease and hemophilia.

Members are identified for enrollment in our Integrated Care Management program through predictive modeling and through referrals from internal staff, members or providers. We use Verisk Health's Diagnostic Cost Groups and predictive modeling system ("DxCG") to identify members at highest risk for future admissions, based on the Prospective Risk Score (indication of future risk for avoidable care) and the Likelihood of Hospitalization Score (predictor of future inpatient hospital care), and we focus our most intensive care management efforts on this group.

- **Member Clinical Summaries and Care Gap Identification** – Select Health facilitates improved care coordination with providers by sharing a Member Clinical Summary, which is a claim-based medical history including pharmacy and medical data, and identified Care Gaps, through our secure Provider Web Portal. Sharing of Care Gap data is especially helpful in identifying issues that if not addressed, could lead to deteriorations in health status resulting in avoidable hospitalization.

- **Utilization Management** (Prior Authorization, Concurrent Review and Discharge Planning) - Our Utilization Management program is designed to ensure members receive the right care, at the right time, in the appropriate setting. We require prior authorization for all elective admissions to maximize the delivery of care in the most cost-effective setting. Our concurrent review nurses assess every admission for conformance to evidence-based medicine protocols, and our discharge planners work with every hospitalized member to

coordinate home services and referrals to Care Coordination to avoid future admissions or re-admissions.

- Pharmacy Coordination – Select Health focuses on pharmacy compliance and appropriateness to help our members stay well and avoid deteriorations in health status that can lead to hospitalization. Our care managers have desktop access to the medication profiles of all members enrolled in our Integrated Care Management program, allowing them to make timely reminders and assist members in understanding how to take their medications as directed. Our regional clinical pharmacist conducts daily rounds with our care managers.

- **Member Health Education and Wellness Programs -** Our programs empower members to take control of their own health and seek to increase member compliance with their care plans.

- **Telemedicine** –Select Health works with home care agencies and other vendors to deploy telemedicine technology, especially in rural communities. We are prepared to coordinate remote blood pressure monitoring using a digital blood pressure monitor within the member's home and remote glucose monitoring using cell phone-connected glucometers.

TRANSITION OF CARE AND DISCHARGE PLANNING

Select Health's approach to the transition of care management for hospital discharges and for controlling hospital readmissions, includes the following components:

- A best-in-class integrated data platform to inform care planning
- A collaborative transition of care team and on-site acute care transition managers in high-volume hospitals
- Post-discharge follow-up and Rapid Response team support
- Robust data analytics using the 3M Health Information Systems algorithms
- Shared savings models with hospitals

Select Health's Integrated Care Management platform provides a complete member profile showing diagnostic information, medical and pharmacy utilization history, and social data such as family and support system availability. The data included in this system provide the foundation for transition of care planning and all efforts to control avoidable readmissions.

When a member is hospitalized, our care managers or the PCMH care managers use the information contained in our Integrated Care Management system develop a successful, person-centered discharge plan. A plan is developed in collaboration with the member and/or caregiver, treating physicians, hospital social worker as well as with the HCBS care manager to align all parties with the transition goals. As discharge approaches, the Select Health care managers work with all key parties to coordinate home health services, specialty care and DME services to ensure a seamless

transition and prevent any gaps in ongoing treatment that could result in negative health outcomes and costly readmissions.

Select Health will place acute care transition managers on site at certain high-volume hospitals, to help coordinate care for hospitalized members. The transition managers visit hospitalized members, assessing their discharge needs, coordinating post-discharge physician appointments, and arranging needed equipment and supplies. The transition manager also alerts the Integrated Care Management team when a member is nearing discharge and will arrange for ongoing support from the team. The transition manager serves as a liaison for the facility and activates resources and services provided by the health plan to support the member.

Post-discharge, our transition of care team follows up with discharged members at regular intervals based on the individual plan of care and the member's ongoing needs. The team assists members with self-management techniques and helps eliminate barriers to achieving better health, like overcoming health literacy issues that impede a member's understanding of the plan of care and contribute substantially to member non-compliance resulting in readmission.

Staff can address questions concerning how to obtain medications, supplies or medical equipment, offer assistance in finding a specialist, and how to get help with making physician appointments. Ongoing medication monitoring assures the member is meeting their responsibility of remaining up-to-date with prescriptions, while those found to be noncompliant are given a call to action and guidance on obtaining all needed medications.

Select Health will continuously monitor the following key measures for all acute care hospital discharges:

- Physician visits within seven and 30 days of discharge
- Readmissions within 30 days of discharge
- Potentially Preventable Readmissions (Using 3M Health Information Systems' methodology)

Results of our evaluation drive improvement and performance goals, both internally and for under-performing facilities.

VI. CARE COORDINATION

5. What care coordination strategies would your organization employ for smaller or more rural PCMHs (e.g., sharing of Care Coordinators by PCMHs and/or between CICOs and PCMHs)?

Select Health has a track record of working with PCHMs to support members with complex needs in various settings. Our approach focuses on the care plan and supporting the PCHMs removal of any barriers to care that can that can lead to poor health outcomes.

PROVIDER ENGAGEMENT

The relationship between the provider and member is one of the strongest tools we possess for changing member behavior. In rural areas with low PCP density, we will expand access to care by contracting with pharmacies to provide counseling services for members with high blood pressure that fall within the pharmacists' scope of practice, but go beyond traditional medication counseling. We will also ensure that all providers have accurate and up-to-date data on member medications and offer Pay-for-Performance incentives for achievement of HEDIS® completion rates.

We will consistenly track patient volumn at rural provider offices, with the goal of establishing PCMHs, whenever possible.

COORDINATING SERVICE PLANNING AND DELIVERY

Our planning process begins with a review of the member's health information. We identify all prior health care issues and past services. Information gathered from the member Care Coordination Survey included in our New Member Welcome Packet and completed during new member welcome outreach calls and other care management tools, provides a template of the member's needs and available supports, while data gathered from the member's treating physician, hospital social worker and other involved healthcare professionals, provide a blueprint of care needs.

These care needs are combined into a care plan that is then managed by the PCMH, if available, or through the Select Health care management team. Of course, these become more challenging to create in a rural setting when a member and provider are not able to interact as easily.

Technology

Technology offers an alternative way of reaching members in rural areas by increasing the flow of information. We have seen that such use of technology to remotely support our members improves member adherence to care plans, resulting in improved health outcomes.

Telehealth

Select Health offers a Telehealth program for members with high blood pressure. Members with high blood pressure will receive a wireless digital blood pressure monitor for home use. The monitor automatically stores and sends the member's health information to the integrated care team including the PCP and Select health care manager. This process alerts all key parties to fluctuations in the member's blood pressure, allowing for timely intervention. This can be particularly powerful

in rural markets where limited resources require the integrated care team to be accurate and impactful with its resources.

Home Test Kits

Select Health's affiliated plan in Pennsylvania recently piloted home HbA1c and LDL test kits. The kits contain easy-to-use instructions and materials for collection of a finger-stick blood sample that is mailed to a certified laboratory for processing, saving the member from a separate trip to a laboratory site. The data collected from these at-home test kits are shared with the member's integrated care team.

24/7 Nurse Line

Our 24/7 Nurse Line provides members with access to symptom counseling and healthcare guidance by a registered nurse. This is particularly helpful for a rural population, as clinical counseling is made available at all times to any member with access to a telephone. A summary of the member's interaction with the 24/7 Nurse Line is faxed to the integrated care tea, and to Select Health's Rapid Response team. Our Rapid Response care connectors subsequently contact the member to assess any additional needs and to help reconnect the member with the PCP, if appropriate.

Member and Provider Portal

Currently, members and providers have access to our secure web portals, which contain detailed information about care gaps and medication history. Care gaps are recommended services supported by evidence-based clinical practice guidelines (such as LDL-C and blood pressure testing) for which there is no claim evidence that the member received the service.

We find the portal is particularly helpful within the rural community as it ensure when a member is in contact with a provider, that all Care Gaps are filled, versus the provider simply treating the presenting symptoms. This information also supports a member becoming their own health advocate, understanding what Care Gaps they should focus on.

COMMUNITY OUTREACH

Select Health sponsors and participates in hundreds of local health-related events annually to bring health care directly to the communities we serve. In a rural market, where there are fewer resources, this allows Select Health and supporting providers to create member concentration, even for just a brief period of time.

To support blood pressure management, these events offer blood pressure testing, nutrition counseling, medication adherence counseling, as well as a connection to the PCMH, should a member need greater support in closing their care gaps and following their care plan.

VI. CARE COORDINATION

6. The CICO would be ultimately responsible for all services provided, including care coordination. What should be contractually required of the CICO to ensure compliance with service delivery and care coordination?

A key step in ensuring CICOs understand how to the meet the requirements of the demonstration project are creating a contract with clear goals and well defined service expectations. Select Health hopes that this question and response is just the beginning of conversations with SC DHHS in regards to this topic.

Select Health fundamentally believes an effective, integrated care program must be built on a single contract with two or more licensed and accredited, risk-bearing CICOs responsible for managing and coordinating care for all eligible members. Other qualifications that can be considered may include prior experience with the South Carolina members and providers, aged, blind and disabled populations as well as experience with the delivery of psycho-social supports in conjunction with medical management.

The SC DHHS proposal to CMS includes a number of quality targets (Appendix N) that may serve as proxies for effective service delivery and care coordination. Given the demonstration nature of this program and the new approach to integrating Medicare and Medicaid payment streams and resultant CICO rate structure, we also recommend that CMS and SC DHHS reconsider the proposed structure of the quality incentive program. In lieu of a withhold from the base capitation rate, we recommend that a subset of the quality and outcomes targets be used in an incentive program much like the Medicare Advantage "Stars" quality bonus program to incent CICO for rapid development and execution of effective care coordination programs that meet these criteria. This bonus approach would also incent CICOs to continuously measure performance towards goals and, as necessary, modify existing programs in order to improve the likelihood of earning these bonuses.

Other program measures are described in Section D.ii describing consumer protections and in Section F described expected outcomes. While we anticipate that elements of these measures will be included in the proposed contract, we also recommend that CMS and SC DHHS consider limiting the majority of measures and reports to those that may currently exist under either the Medicare or Medicaid program (e.g. HEDIS measures, CAHPS surveys, encounter data, Part D reporting, EQRO requirements, etc.) in order to reduce administrative complexity, redundancy and cost to the CICO and to CMS and SC DHHS. Of course, as discussed in this section, Select Health's service delivery and care coordination management processes are always customized and tailored for the markets we operate. We would look for the opportunity to partner with SC DHHS to come up with the idea measures while limiting the administrative complexities.

Finally, we also recommend avoiding the imposition of any performance bonds or like measures in the contract. Given the existing risk-based capital (RBC) requirements, the unknown CICO rate structure, and the other performance measures discussed above, a performance or surety bond would represent an additional financial burden to achieve a program goal that may already be addressed through other means.

VI. CARE COORDINATION

7. Describe how your organization will facilitate safe and effective transitions between providers across systems of care. Would this approach differ for long-term care (LTC) services?

Select Health has established policies and procedures to ensure a smooth transition for members who transfer between providers and across systems of care during the initial enrollment and auto-assignment period and on an ongoing basis.

COORDINATION DURING THE INITIAL ENROLLMENT AND AUTO-ASSIGNMENT PERIOD

Select Health's approach to coordinating seamless transitions for members during the initial enrollment and auto-assignment period is informed by our experience. From this experience, we understand that seamless transitions can be achieved through the following key steps:

- Developing a comprehensive provider network to minimize the need for newly enrolled members to change providers.
- Educating members and providers about the continuity of care provisions afforded to transitioning members that allow members to continue an ongoing course of treatment with a non-participating provider.
- Completing new member welcome calls to ensure new members received a welcome packet and their identification card with their PCP assignment.
- Completing a Health Risk Assessment on new members to identify those with continuing or unmet needs and connecting them to our Rapid Response team for immediate intervention and/or to our Care Management program.
- Engaging in extensive education and outreach in the community to help members and community partners understand our plan and provide information on who to call for assistance.

ONGOING COORDINATION OF CARE

To facilitate seamless care transitions on an ongoing basis, we rely on the same key steps taken during the initial selection and auto-assignment process and supplement those with our proven systems and processes to support data sharing and information exchange.

Interdisciplinary Care Team

The Model of Care is supported by a variety of staff across the organization including those in administrative roles, clinical roles and those in oversight roles. The Interdisciplinary Care Team (ICT) is a group of professionals, paraprofessionals and non-professionals who possess the knowledge, skill and expertise necessary to accurately identify the comprehensive array of the beneficiary's needs, identify appropriate services, and design specialized programs responsive to those needs.

The composition of the ICT varies according to the beneficiary's individual care needs. In addition to the beneficiary and/or caregiver, ICT members may include health plan physicians, nurses, social workers and pharmacists, the beneficiary's primary care physician (PCP), specialists and ancillary providers involved in the beneficiary's treatment and community resource staff. In focusing on the demonstration population, this ICT will also include the HCBS care manager.

Member Clinical Summary

Our Member Clinical Summary (MCS) helps ease transitions by capturing a claim-based medical history including pharmacy and medical management data sets and any care gaps. Our Rapid Response team is always available to facilitate immediate interventions to achieve seamless transitions, from assisting members in getting prescription drug orders and medical records transferred to new pharmacies or providers, to quickly meeting any needs for equipment and supplies that could otherwise be interrupted while transitioning between systems.

Working with both the member and our health plan counterparts, we share health information relevant to the member's current plan of care, preventing any gaps in ongoing treatment that could otherwise result in negative and costly health outcomes.

Collaboration with Other Delivery Systems

Select Health routinely makes contact with other delivery systems in our market to facilitate collaboration for members who move from one system to another. We also have a detailed Member Clinical Summary, discussed above, that can be shared with the new delivery system and/or any new physicians seeing the member.

LONG-TERM CARE TRANSITION MANAGEMENT

Select Health will leverage the same strategies of planning, communicating and monitoring when facilitating safe and effective transitions within the long-term care (LTC) setting. In other words, the LTC program will proactively coordinate information sharing and service delivery across care transitions.

Proactive transition management begins with a system of access and alerts designed to avoid preventable episodes of care. Members will receive routine contact from LTC program staff to assess for changes in their condition that may be the start of deterioration. Key indicators will be reviewed with the member and/or care giver to identify subtle changes.

Should the tracking process identify any change in the member's condition or activity pattern, a home visit will be scheduled to assess the member and adjust the treatment regimen. If additional care is needed, the home provider will coordinate transfer to the appropriate setting. Copies of the member's care plan are sent with the member.

For members in a facility, the LTC care manager will work with the facility staff to plan for services and follow-up needed for discharge. The care manager will review the member's medications with the facility care team and assists in reconciling them with the member's prior medication regimen. Members who are discharged will be visited by a member of the care team within 24 hours of discharge to ensure that needed services are in place and instructions are understood. As part of the

discharge process, an appointment will be made for a primary care visit, either in the office or in the member's home. The care manager will adjust the plan of care to include check points with the member to identify any barriers to keeping the appointment and assist in arranging transportation, if needed.

VII. NETWORK & SERVICES

1. Please identify and discuss any specific challenges or special considerations your organization considers important for addressing the unique and complex health care needs of the elderly population in the following areas: a. Nursing facilities; b. Behavioral health; and c. Specialty physicians (e.g., geriatric medicine)

Based on the data provided in Appendices C, D and E, the target population exhibits a high incidence of chronic disease including cardiovascular disease (24.4 percent), diabetes (16.7 percent), renal disease (15.6 percent), pulmonary disease (10.7 percent), metabolic disorders (10.2 percent) and psychiatric conditions (9.5 percent). In addition, 45 percent have some impairment in their ability to perform activities of daily living with a significant number utilizing some nursing facility and home-based care. Between 13 and 17 percent (depending on the age bracket, all ages above 65) of their encounters with physicians occur in the emergency room.

To address the needs of this population in nursing facilities, behavioral health and specialty physicians, a model of care is needed that focuses on improving health outcomes for the population through coordination of services using an identified point of contact with timely access to essential services. The model needs to effectively corral physical health, behavioral health, pharmacy and community-based services into a cohesive web of service that is individual to each member. The following four elements are special considerations that will need to be considered when implementing the model successfully:

- **Data-drive interventions** – The model needs to incorporate analysis of all available data to identify members with impactable conditions, risk for future avoidable episodes of care and likelihood of future inpatient admission. In addition to this predictive data modeling, the model should use data to guide outreach and education on specific evidence based guidelines relevant to the population, including chronic condition management, medication management and primary and secondary prevention.

- **Member engagement** – Proven strategies to connect with members where they live and around the problems and issues that are facing them beyond their health care. The social and environmental issues faced by this membership are as much drivers of their health outcomes as their knowledge of their clinical condition.

- **Provider Engagement** – Programs to actively involve providers in improving health outcomes are essential for the model's success. In addition to payment methodologies that reward performance, the model needs to have transparent and reliable data-sharing and communication programs to ensure that everyone involved in the member's care has the same information.

- **Care Integration** – To truly succeed in meeting the needs of this population, the model needs to function seamlessly across all of the care silos and settings, from behavioral health to acute inpatient care to outpatient pharmacy. Programs carving out segments to vendors will not be able to deliver the comprehensive web of services necessary to support these complex members.

VII. NETWORK & SERVICES

2. What criteria determine the adequacy of a CICO's provider network?

Select Health seeks to maximize access to care for our members. We take an inclusive approach to provider contracting and use Geo Access mapping to track contracting results. We strive to contract with all available providers who meet our credentialing standards and work to refine the network over time, as needed, to ensure we retain providers who meet our network and quality requirements. While establishing and maintaining the Select Health network, we considered several aspects of access including, but not limited to, the following:

- Our anticipated enrollment and the expected utilization of services, considering the characteristics and health care needs of the populations
- The numbers of network providers who are not accepting new Medicaid patients
- The geographic location of providers and members, considering distance, travel time, commonly used means of transportation and provisions for physical access for members with disabilities

We also work with our contracting entity to ensure our network meets contracting requirements. On January 25, 2012, Melanie Bella, Director of Medicare-Medicaid Coordination released a memo offering some additional guidance on the national demonstration projects. This memo can be reviewed at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf.

In summary, it appears that CMS is encouraging Medicaid standards of access for long-term care, Medicare standards for medical services and prescription drugs while noting that services of overlap between Medicare and Medicaid, network standards will be negotiation via MOU negotiation, "so long as such requirements result in a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area".

Select Health is supportive of this guiding principle and is confident that our established network and network build out would meet this requirement.

VII. NETWORK & SERVICES

3. What criteria determine if a Beneficiary has appropriate access to services?

As discussed in question #2 above, Select Health seeks to maximize access to care for our members. Providers are contractually required to meet standards for timely access to care and services, taking into account the urgency of the need for the services. In addition to the standards communicated in a provider's contract, access and appointment availability standards are routinely communicated via the provider manual (also available on line), provider website, on-site orientation of new providers, ongoing training and the provider newsletter.

Once the accessibility standards have been communicated to providers, follow-up contact with the providers ensures that the member's experience is consistent with these standards. Compliance with the accessibility standards is monitored through a number of tracking and reporting vehicles. We track calls from members related to dissatisfaction with appointment and wait times. Individual complaints are forwarded to the Provider Contracting Representative assigned to the provider for investigation and resolution. In addition, aggregate complaint data related to dissatisfaction with appointments and wait times is trended to identify physician offices with repeated problems.

We also conduct assessments via "secret shopper" surveys, as well as provider audits. Secret shopper calls allow us to directly experience the response from the physician's office that our members receive. For this assessment, we call physician offices after normal business hours to verify whether members who call at this time are able to reach a physician, if necessary. We also audit provider scheduling records to determine the availability of the next appointment for preventive, routine, and urgent care. During on-site visits, we monitor office wait times.

Providers who are non-compliant with any of the accessibility standards are notified of our findings by their provider contracting representative and re-instructed regarding the standards. The assigned provider contracting representative schedules another monitoring event, either an on-site visit to monitor office wait times, a secret shopper call to check appointment availability or an after-hours call to verify the availability of the practitioner.

Offices that are non-compliant during repeated monitoring attempts are required to prepare and implement a corrective action plan. The provider contracting representative monitors the implementation of any correction action and reports the results to the Quality Service Committee. Non-compliant offices are also automatically included in the provider list for the next monitoring session.

Our provider contracting representatives work with provider offices to assist them in implementing creative solutions and adjusting their processes to become more compliant.

We also work with our contracting entity to ensure that our network meets contracting requirements.

VII. NETWORK & SERVICES

4. Provide a description of the health and wellness programs your organization would employ, adopt, and/or promote as part of this Demonstration. Responses should include considerations for the following elements:

a. Health promotion and wellness

b. Evidenced-based chronic disease self-management practices

c. The achievement of positive health outcomes

Select Health encourages independence and personal responsibility to promote positive health outcomes and control program costs. Our strategy focuses on empowerment through engagement and education, and is interwoven in all components of our clinical programs. This is coupled with innovative and award-winning community-based wellness programs and member incentives to engage members in taking control of their health. All behaviors supported and encouraged by our wellness programs are rooted in our Integrated Care Plans, which guide members towards evidence-based chronic disease self-management practices. Our prominent programs and incentives, described below, also all have documented positive health outcomes and success.

MEMBER WELLNESS PROGRAMS AND INCENTIVES

Select Health effectively engages members in their own health by partnering with them and with community leaders, faith-based organizations and agencies already trusted in the community. By establishing a relationship of mutual trust, we help the member become an active participant in their care. A key component to all of our programs is a specific and clear call to action, defining a path for the member to use in addressing the target behavior or care need.

- **Healthy Hoops® -** Our NCQA award-winning program uses basketball to educate pediatric members with asthma and their families about asthma management and obesity prevention.
- **Lose-to-Win** – Our URAC award-winning program uses a contest format loosely mirrored on TV's "Biggest Loser" to educate and engage members with type-2 diabetes and obesity on nutrition and exercise. Although Lose-to-Win has not historically been offered in the South Carolina market, it has been found affective amongst certain populations in affiliated plans. Its use would be considered for the demonstration project.
- **Women's Health Ministry 40-Day Journey -** This NCQA-recognized program focuses on improving the health of African-American women and their families through a multi-week educational series emphasizing nutrition, exercise, medication compliance and water intake.
- **Know Your Numbers -** This program stresses the importance of knowing key health numbers, including blood pressure, cholesterol level and blood sugar level.

- **Prepare For Your Visit** -This personal responsibility program provides an easy-to-use guide to help a member ask the right questions during their doctor's visit.

- **Smoking Cessation and Nutritional Support** –Members are eligible for 70 tobacco cessation counseling sessions. Members who are eligible for pharmacy services can get tobacco cessation drug medicines like bupropion and the generic nicotine patch. Members are also provided with access to registered dieticians and nutritional counselors. Although Smoking Cessation and Nutritional Support has not historically been offered in the South Carolina market, it has been found affective amongst certain populations in affiliated plans. Its use would be considered for the demonstration project.

Select Health uses health incentives to increase members' motivation and willingness to change and maintain healthy lifestyles. We adjust our member incentive programs over time based on our retrospective evaluation of the effectiveness of each incentive and ensure that incentives target those areas most in need of improved outcomes.

VIII. PAYMENT REFORM/INCENTIVES

1. Provide a description of the types of alternative payment, incentives, incentive and/or shared savings program(s) your organization utilizes for any of the following: a. Physicians; b. Hospitals; c. Multiple provider settings (e.g. Accountable Care Organizations (ACOs))

Select Health believes that sharing actionable data, along with aligned incentives, can change the way that providers deliver care to create a more efficient and higher quality system of care. Below, please find a summary of the alternative payment, incentives, and shared savings programs we offer to providers to create more efficient and effective healthcare system. Although these methods have not historically been offered in the South Carolina market, they have been piloted in affiliated plans and show initial promising results. Use of these methods will be considered with the demonstration project.

PRIMARY CARE INCENTIVE PROGRAMS

Select Health utilizes incentive programs that provide recognition for performance as well as an incentive for improvement. The program criteria include quality, utilization and administrative components in an effort to offer comprehensive programs that support provider and health plan initiatives.

The PCP incentive programs focus on providing PCPs with actionable data about the health of their assigned panel. Provider Account Managers meet regularly with PCPs and educate them on the data available to them. This education, and real-time access to information, has the potential to drive PCPs to optimize their reimbursement and simultaneously improve the health of their patients.

SPECIALIST INCENTIVE PROGRAMS

Programs have also been developed to recognize and incentivize quality and efficiency for high volume specialties such as OB-GYN, cardiology, oncology. The programs incentivize quality and efficiency. The criteria are consistent with national association practice guidelines and are developed with provider input.

As with the PCP incentive programs discussed above, the specialist incentive programs also include a focus on providing the specialists with actionable data. Provider Account Managers meet regularly with them and educate them on the data available to them. This education, and real-time access to information, has the potential to drive specialists to optimize their reimbursement and simultaneously improve the health of their patients.

HOSPITAL PROGRAMS

Select Health's Shared Savings program captures the key components of effective health care delivery and represents a major shift from fragmented, volume-driven reimbursement to active and collaborative provider engagement. The primary theme of the program is to promote timely and appropriate ambulatory care, thereby mitigating the need for emergency room treatment, unnecessary inpatient admissions, and clinically inappropriate readmissions.

The shared savings program is a step towards an accountable care model. We have received more traction in the market from this intermediate step, than seeking providers interested in implementing a full risk ACO model.

The key components of this collaborative model are built upon a foundation provided by 3M's "Potentially Preventable Readmission" logic and AHRQ's "Ambulatory Care Sensitive Conditions." These algorithms provide the necessary risk adjustment and condition-specific guidelines to calibrate the readmission and avoidable initial admission criteria.

In addition to traditional trend improvement goals, quality-based incentives are included to ensure Select Health's members are receiving appropriate care. The purpose of these incentives is to narrow any gaps between current performance and regional & national "top tier" performance rates.

The shared savings model is an approach that engages both providers and patients in the shared goal of better outcomes and health care value. As innovation and delivery models evolve, Select Health will continue to incorporate new methods and approaches to ensure we are truly aligned and engaged in the effort of improving health care quality and promoting "Accountable Care."

The Model

The model begins with a bonus pool allocation equal to an agreed upon percentage of the facility/facilities annual spend. This pool is then allocated to 7 domains:

- Potentially Preventable Admission Rate
- Potentially Preventable Emergency Room Visits
- Potentially Preventable Readmission Rate
- NICU admission Rate
- Obstetric and Primary Care HEDIS measures
- C-Section Rate
- Appropriate Care Measures

Facilities are compared to both prior performance (trend) and peer relativity (network). Compensation is based upon performance in both domains. For the first year of the agreement, all performance calculations and metrics will be based upon network relativity. Year 2 and 3 of the shared savings program will contain both trend and network relativity performance.

VIII. PAYMENT REFORM/INCENTIVES

2. Provide a description of the types of innovative strategies and incentives your organization considers to be the most effective for encouraging CICOs and PCMHs to engage in each of the following: a. Deliver care in home and community-based settings; b. Avoid hospitalization, re-hospitalization, and c. Support the transition of Beneficiaries between care settings

Select Health's mission is to help people: Get care, stay well and build healthy communities. This mission translates to our goal of providing our members high quality and cost effective care. We can only achieve this goal if our members are being cared for in the least restrictive level of care possible, by best in class health care teams, supporting smooth transitions between care settings. Select Health drives to these outcomes by sharing actionable data with care teams and aligning incentives.

Below, please find a summary of strategies Select Health believes would improve our ability to drive high quality and efficient care for our members:

PAYMENT FLEXIBILITY TO SUPPORT PATIENT CENTERED MEDICAL CARE NEEDS

SC DDHS should consider allocating flexibility in funds to CICOs to provide enhanced/additional services necessary to meet beneficiary person-centered planning expectations. Such flexibly in a payment structure would support a transition from today's disjointed, fee-for-service model of care to a scenario of care integration, aligned incentives and the PCMH's management of members' care.

This flexibility would further free CICOs to invest resources into its integrated care team ensuring all resources are available to members. This could help ensure that all key interdisciplinary team members actively participate in ongoing member care and allow the CICO to provide for supplemental services when there is no immediate availability. Lastly, this would allow for the potential of higher payment for higher quality of care to members.

INTEGRATED DATA SYSTEMS ALLOWING HISTORIC CLAIMS DATA AND FUTURE DATA TO BE SHARED ACROSS ALL POTENTIAL STAKEHOLDERS

Select Health understands SC DHHS interest in CICO's developing information technology exchanges to support member care coordination. As discussed, Select Health has made significant strides in this arena and is well positioned to support the go-live of its D-SNP model of care January, 2013, including the integration of the multidisciplinary care team.

To effectively coordinate and manage member care, Select Health requests that SC DHHS facilitate the timely transfer of participant information (including assessments and care plans) through a centralized database or electronic health record. A common technology platform will facilitate secure and HIPPA-compliant communication across entities and throughout the continuum of care, improving patient safety and reducing the potential for duplication of services or unmet gaps in care.

CICOs and providers must have access to comprehensive and timely information in order to optimize a member's care. As an alternative to each CICO building its own information technology

exchange, SC DHHS could coordinate development of a standard platform that can be used by all CICOs.

Management entities should have access to historical claims data for new members. They must also have access to assessment data and care plan information, and this information should follow members as they move from one management entity to another. Ideally, the information will be housed in a centralized location.

VIII. PAYMENT REFORM/INCENTIVES

3. How will you operationalize the concept of "value based purchasing" of health care (as defined by CMS) in the construct of your provider networks?

Select Health shares CMS' commitment "to transforming the quality of hospital care by realigning hospitals' financial incentives". We believe that we can change the way care is delivered to our members by connecting actionable data with aligned incentives. To that end, the foundation of this program will be data. Data will be used to identify and reward providers that perform best on quality and cost measure and also used to identify and measure opportunities for performance improvement, and ultimately to make future contracting decisions.

As ultimately defined, all key program elements and data will be available to providers via our Provider Portal. As discussed in greater detail above, this web based network solution is highly customizable and is already in use at the hospitals, clinics and individual provider offices.

Select Health's value-based program will support the CMS initiative specifically in our hospital provider network. To support the current CMS model for Hospital Value Based Purchasing, Select Health will complete a comprehensive review of the demographic data of the new membership and their chronic care needs.

This membership review is a critical step in our process and a clear distinction, as the current CMS Value Based Purchasing Plan is based upon the general Medicare population. A comprehensive review is needed and is critical for the special needs of this patient population because the care of these patients is very complex and will likely differ from the rest of the Medicare population. The review will include their complex medical needs, the needed quality outcomes, and the current status of these outcomes.

Data will be compared to the identified quality indicators of the CMS Hospital Value Based Purchasing Plan for applicability. When necessary, quality indicators will be customized to the specific provider to allow that provider to focus on improving the clinical outcomes most relevant to their scope of practice. If additional quality metrics are needed based upon the chronic care needs of the membership, these will be developed and included in the plan and implementation.

This approach will allow us to support the existing CMS initiatives but also allow minor tailoring of the program, if needed, to reach the quality of care outcomes specific to this patient population. To support the providers and ensure quality of care is met for these members, Select Health also incorporates interdisciplinary teams in our clinical care services including behavioral health and home based programs.

Additionally, the CMS Hospital Value Based Purchasing Plan includes an identified methodology and incentive payment structure. The incentive as designed by CMS for the Hospital Value Based Purchasing Plan provides reimbursement to providers for improved health outcomes. Select Health will support the current CMS initiatives by incorporating reimbursement to our providers for improved health outcomes associated with the complex needs of the members.

VIII. PAYMENT REFORM/INCENTIVES

4. Medicare and Medicaid (SC DHHS) will engage in a joint rate-setting process. Provide comments about the principles that should guide CMS and SC DHHS in the development of the rate-setting process.

Implementation of actuarially sound rates is necessary to maintain program sustainability. Select Health appreciates SC DHHS's commitment to actuarially sound rate development.

The stated intent of the CMS/SC DHHS joint rate-setting process is to "test whether aligning Medicare and Medicaid financing can foster more person-centered care models, achieve better outcomes, and lower costs through improvement." The following summarizes Select Health's recommended guiding principles to be considered during the rate development design:

DEVELOP ACTUARIALLY SOUND CAPITATION RATES:

- Based on analysis of CMS and State based historical cost and utilization experience, develop stratified rate categories which accurately reflect the widely varied costs and relative risks associated with a diverse beneficiary population (e.g. institutionalized members, age splits, etc.).
- Utilize the final SGR (RBRVS update), rather than the estimated SGR included in the published Medicare standardized FFS county rates, in the Medicare Fee for Service baseline.
- Include an allocation of CMS expense related to bad debt for this membership in the Medicare Fee for Service baseline. This is a real expense of CMS for this membership and the plans will experience provider pressure to include this in reimbursement agreements.
- Provide for the full range of benefits covered in the Demonstration and appropriate incentives to encourage service providers to undertake a collaborative role in person-centered care models.
- Ensure transparency of rate development process including early release and opportunity to comment on underlying assumptions.
- Fully demonstrate all assumptions and adjustments made to baseline data during the rate development process, including but not limited to, program changes, utilization, reimbursement levels, trends and cost savings.
- Include an adequate provision for administrative expenses in the payment rates.
- Consider expanding the quality bonus payment beyond a withhold to include an incentive payment based on star ratings similar to the Medicare Advantage program.

INCLUDE A RISK-ADJUSTMENT METHODOLOGY THAT ENSURES APPROPRIATE PAYMENTS TO CICOS BASED ON THE RISK ASSUMED:

- Employ a risk adjustment model which sufficiently accounts for the type and severity of diagnosis associated with the CICOs participants.
- Make sure risk adjusters /rate categories and payment rates adequately compensate for long term care services once a member's status changes to institutionalized.
- Incorporate a Frailty Adjustment that reflects beneficiary functional status (e.g. ADLs) into the risk adjustment process in recognition of the fact that this will measure relative costs not reflected in the risk adjustment model.
- Further enhance the model over time to move towards a single comprehensive model which accurately predicts costs of the dual population over time, reinforcing the goals of full integration and simplification of administrative functions for efficiency of the program.
- Perform ongoing validations on the consistency of data through employment of CMS and State shared data sets on eligibles.
- Define timing and processes for updating and refining the risk adjustment process as additional experience is gained through the demonstration period.

ENSURE CICO VIABILITY THROUGH LIMITATION OF RISK THROUGH REASONABLE COST SAVINGS ESTIMATES AND USE OF RISK CORRIDORS:

- Any savings adjustment for members coming from the Medicare Advantage program should consider that the capitation rates already reflect managed care savings relative to FFS.
- Given that this is a demonstration project without historical experience to evaluate projected savings, minimal savings from the original fee for service program should be used in rate setting (around 1%).
- Establish appropriate risk corridors to protect plans from excess losses, particularly if MLR rebates apply to this program. Preferably, the MLR rule would not apply to this program, rather a risk corridor would be implemented, including upside and downside risk.
- Risk corridors would be applied from the perspective of an integrated program, based on combined Medicaid and Medicare experience.
- To further limit risk exposure, losses or profits from prior periods would be carried-over into subsequent years of the demonstration project.

VIII. PAYMENT REFORM/INCENTIVES

5. What requirements should be included contractually regarding sharing clinical and other performance information at the individual provider level, facility level, and by service line?

We support SC DHHS' and CMS' goals of achieving transparency and in creating tools that would allow beneficiaries to identify and select high-quality providers and facilities for their healthcare needs. To achieve this, we recommend that DHHS and CMS define the quality measures and data definitions to eliminate reporting variation between CICOs and to then mandate acceptance as part of the contracting process. We further suggest that SC DHHS consider aligning data definitions and quality measures with Medicare and/or Medicaid programs. Not only will this ease administrative burdens on CICOs and providers, it will also allow the Demonstration to take-advantage of historical data and baseline data.

Finally, we highly recommend the use of proxy measures in lieu of specific quantitative data in reporting quality to the general public. Much like the Medicare Advantage "Stars" program, we propose a tiered or band approach, creating comparable scores for providers, hospitals and service lines without creating controversy or confusion as might arise with the use of specific detailed metrics. The broad acceptance and adoption of the "Stars Program" speaks to the viability of this approach. We would further recommend that DHHS and CMS define this program thoroughly to eliminate reporting variation between CICOs and to then mandate acceptance as part of the contracting process.

VIII. PAYMENT REFORM/INCENTIVES

6. How does your organization currently offer: (a) Reference pricing and/or (b) Financial transparency? If yes, describe how the information is shared with others.

Select Health has significant experience contracting in the South Carolina market. We always hold ourselves out as a champion of our providers and see them as our partners in providing high quality and efficient care to our members. To that end, it is important to us that our providers are fairly compensated for the work they do.

We continue to refine our PCP, specialists and hospital payment programs. These programs include incentives for quality and overall value of care provided. Under the new SC DHHS incentive program, we expect to build more PCMHs and look to provide additional compensation for provider participations on our multidisciplinary care teams. Looking to the demonstration projects, we are particularly interested in expanding the richness of this payment structure.

Our goal is to be open and honest with our providers and our members about our payment triggers. Clinical information is shared with members and providers via our Portals, and as discussed in greater detail above, even pushes the provider quality data to our members. Additionally, Provider Account Managers regularly meet with our providers and discuss their performance on these programs and encourage them to always take a greater and more active role in these programs.

VIII. PAYMENT REFORM/INCENTIVES

7. The Partner for Patients is a quality initiative related to Medicare hospital reimbursement. Please describe any alignment your organization has with the initiative, including measures used for engagement efforts and performance-based payments, hospital performance and reimbursement for the following: a. Inpatient quality reporting; b. Mortality Measures; c. Hospital Acquired Conditions (HACs); d. Patient`s Experience of Care; and e. Others

The Partnership for Patients is a public-private partnership that strives to improve the quality, safety and affordability of health care for all Americans. According to The Partnership's website, they have more than 7,600 partners, including over 3,300 hospitals as well as physicians and nurses groups, consumer groups, and employers.[1]

The two goals of the partnership are first, to keep patients from getting injured or more sick and second, to help patients heal without complications. The Partnership has two main vehicles that drive change. The first is their Hospital Engagement Networks, which is learning collaborative for hospitals and provides them with initiatives and activities to improve patient safety. The second is their Community-based Care Transitions Program (CCPT), which is a partnership between community based organizations and acute-care hospitals to decrease preventable complications during a transition from one care setting to another.

As described in greater detail in the Quality sections of this response, Select Health recognizes that quality assessment, measurement and subsequent improvement are critical to providing high quality and cost efficient care to members. Select Health is very much aligned with the goals of the Partner for Patients organization and has extensive experience in providing similar quality and performance-based evaluation through our formal Quality Assessment and Performance Improvement (QAPI) program, which supports our achievement of similar goals. In fact, of the 37 acute care Partnership for Patients hospitals (excluding VA and military facilities) in South Carolina, Select Health is currently contracts with 33 of them and intends to expand our current relationship to include the demonstration.

Select Health expects to partner with SC DHHS to customize the QAPI program offerings to support specific quality goals and program evaluation. Similar to the Partner for Patients initiative, past QAPI programs have included, but have not been limited to, review of hospital performance on inpatient quality reporting, mortality measures, HACS and the patient experience of care. Additionally, as discussed in greater detail in the Network & Services section of this document, Select Health is currently engaging hospitals in Value Based Purchasing discussions, including consideration of these quality metrics as well.

Select Health's QAPI program adheres to the program structure requirements mandated by NCQA. Our QAPI program integrates knowledge, structure, and processes throughout the health care delivery system to assess risk and improve both the quality and safety of clinical care and services provided to enrollees. The QAPI program provides the infrastructure to systematically monitor,

[1] http://www.healthcare.gov/compare/partnership-for-patients/about/index.html

objectively evaluate, and ultimately improve the quality, appropriateness, efficiency, effectiveness, and safety of the care and service provided to members.

The established QAPI program involves resources and leaders from all areas within Select Health. QAPI goals and initiatives are an integral part of Select Health and are incorporated into department goals and individual staff goal planners to ensure visibility and appropriate attention to QAPI program execution.

Historically, the areas targeted for improvement projects are based on an assessment of current performance and where there would be the greatest impact on enrollee outcomes and health status. Areas for focus are identified and prioritized according to their ability to meet the following criteria:

- Clinical importance and scientific validity
- High-risk and/or high-volume service or process
- Relevance to the population
- Alignment with State priorities

In partnering with SC DHHS on this demonstration, we would actively seek opportunities to improve the quality of care and services we provide to our demonstration enrollees and providers by implementing and evaluating these key quality and performance metrics which align with those in the Partners for Patients initiative.

IX. GENERAL

1. What demographic, financial and other information about Dual Eligible would be helpful to your organization's efforts to prepare a response to an RFP for this Demonstration?

Select Health has significant experience getting to know a population of potential members from the members' data. This data holds the record of where the members live, what their care status looks like, what their utilization patterns have historically been and can also help us understand how they interact with their community. Additionally, we look at rate information within the market to understand what our membership needs will be and to assess what provider and member incentives may be possible.

In order to prepare an appropriate response to an RFP for this Demonstration, a potential bidder will need to assess if the projected capitation rates are actuarially sound and will allow a bidder to meet SC DHHS's stated objectives for the program. This entails completion of an analysis of the historical experience of the target population, verifying the fee-for-service trends by category of service, and developing the best estimates of managed care savings for both the Medicare and Medicaid components of the Demonstration.

Select Health sees the following information as necessary and critical in responding to an RFP of this nature.

- A data book that covers at least two years (fiscal or calendar) of medical cost and utilization data for the proposed population. The data should be provided by detailed category of service, Medicare/Medicaid status, geographic area and time period, and should include the member months, units of service, dollar amounts incurred and risk scores. This will allow for the development of the appropriate unit costs and utilization rates. The potential bidder can then estimate the potential managed care savings that could be achieved through provider contracting and care management.
- A data set that includes detailed eligibility and claims information to allow the potential bidder to evaluate the population risk profile and to determine the appropriate protocols that will align with South Carolina's goals and objectives for the Demonstration. A detailed list of recommended elements for data analysis and cost savings projections is included below.
- A list of all programmatic changes, including effective dates of change, for the historical experience periods and for the prospective demonstration period.

RECOMMENDED ELEMENTS FOR DATA ANALYSIS AND COST SAVINGS PROJECTIONS

As noted above, a potential CICO will need to complete analysis of the market opportunity before completing a response to the RFP. Below is a detailed list of recommendations on supporting a CICO completion of this analysis.

File Format

The files should be in a readily readable format such as Text or Microsoft Access databases and should be accompanied by a "Data Dictionary" that defines each data element, units of measurement and criteria for service category assignment. This eliminates any misinterpretation of the data provided. The file transfer protocol should also be defined to allow for ease of data transfers.

Data Quantity and Populations Covered

We recommend that three years of data be provided to allow for credible analysis and reporting, including but not limited to claims experience, emerging trends, provider practices, provider reimbursement, risk stratification and potential for care coordination. We also recommend that the dataset be representative of the entire participant population to be served and continuum of services to be provided by the CICOs. This would include long term care experience to be able to evaluate the potential long term care expenses that will emerge from the target population. Claims data should be at a claim line level and represent the final iteration of the claim (after any adjustments are considered).

The files and field lists below represent the ideal content and structure, with the potential addition of any fields specific to the Demonstration which have not been denoted below but would facilitate our interpretation of the program or data provided. We recognize that all of the data elements listed below may not be available.

Eligibility File (Text or Database)

- Unique Client Identification Number/Key Linker
- Risk Score
- Care Type (MCO/FFS)
- Region/Area
- Gender
- Date of Birth
- Race
- Client Address (City, State, ZIP Code and County)
- Medicaid Eligibility Category
- Medicare Eligibility Category
- Enrollment Start Date
- Enrollment End Date
- Spend-down flag, if applicable
- Third Party Liability Coverage Indicator
- PCP Number, if applicable

Provider File (Text or Database)

- Provider ID/NPI/Taxonomy/Location Codes
- Provider Name
- Provider Type
- Provider Specialty Type
- Provider Address (City, State, ZIP Code and County)
- Par/Non Par Status/Indicator

- PCP Indicator
- Affiliation/System

Institutional Claim File (Text or Database)

- Payment Source (Medicaid/Medicare)
- Payment Type (MCO/FFS)
- Unique Client Identification Number/Key Linker
- Client Medicaid Eligibility Category
- Client Medicare Eligibility Category
- Claim Detail Number (Claim & Claim Line #)
- Claim Status (i.e. Paid, Denied)
- Adjustment/Denial Reason Codes (with descriptions)
- Authorization Indicator
- Provider ID
- Provider Type
- Provider Specialty
- Provider Address
- Service Location
- Claim Type
- First Service Date
- Last Service Date
- Date of Admission
- Date of Discharge
- DRG
- DRG Grouper/Version
- Revenue Code
- Primary and Secondary ICD-9 Diagnosis Codes (at least 9 + admitting)
- ICD-9 Procedure Codes
- Procedure Date
- Total IP Days/
- Days Covered
- Units Billed
- Units Covered/Allowed
- Bill Type
- Place of Service
- Patient Status
- Type of Admit
- Type of Service
- Amount Charged/Billed
- Amount Allowed
- Copayment Amount, if applicable
- TPL Coverage Indicator/Type
- TPL Insurer
- TPL Amount
- Amount Paid
- Date Paid

Professional/Other Claim File (Text or Database)

- Payment Source (Medicaid/Medicare)
- Payment Type (MCO/FFS)
- Unique Client Identification Number/Key Linker
- Client Medicaid Eligibility Category
- Client Medicare Eligibility Category
- Claim Detail Number(Claim & Claim Line #)
- Claim Status (i.e. Paid, Denied)
- Adjustment/Denial Reason Codes (with descriptions)
- Authorization/Referral Indicator
- Provider ID
- Provider Type
- Provider Specialty
- Provider Address
- Service Location
- Service Date(s)
- Claim Type
- Capitation Indicator
- HCPCS / CPT-4 Procedure Codes & Modifiers (all)
- Primary and Secondary ICD-9 Diagnosis Codes(all)
- Units Billed
- Units Covered/Allowed
- Place of Service
- Type of Service
- Amount Charged/Billed
- Amount Allowed
- Copayment Amount, if applicable
- TPL Coverage Indicator/Type
- TPL Insurer
- TPL Amount
- Amount Paid
- Date Paid

Prescription Drug Claim File (Text or Database)

- Payment Source (Medicaid/Medicare)
- Payment Type (MCO/FFS)
- Unique Client Identification Number/Key Linker
- Client Medicaid Eligibility Category/Group
- Client Medicare Eligibility Category/Group
- Claim Detail Number (line # if applicable)
- Claim Status (i.e. Paid, Denied)
- Adjustment/Denial Reason Codes (with descriptions)
- Authorization/Referral Indicator (if applicable)
- Provider ID

- Provider Address (City, State, ZIP Code and County)
- Drug Type
- NDC Code
- Date Dispensed
- Quantity Dispensed
- Generic Pricing Indicator
- Service Location
- Amount Allowed
- Copayment Allowed, if applicable
- TPL Coverage Indicator/Type
- TPL Insurer
- TPL Amount
- Amount Paid

IX. GENERAL

2. What are the most important considerations affecting the financial stability and viability of a CICO organizations under this Demonstration? Responses may include, but are not limited to, the following:

a. Enrollment;

b. The demographics and health status of this Demonstration's target population;

c. Coordination of care;

d. Provider networks; and

e. The CICO's administrative, managerial and/or oversight of this Demonstration

Select Health and its parent organization, AmeriHealth Mercy Health Plan, have vast experience managing previously unmanaged populations of membership. Just to name a few examples, in 2008, we took over the management of 40,000 ABD members in our Indiana plan to great success, with significant documented cost savings to the state of Indiana and improved care for members. Just this year, we have gone live with a Medicaid plan in the state of Louisiana, where we now hold over 140,000 lives that were also previously unmanaged.

When a CICO makes its final decision to enter a market or not, it will also need to consider the overall market strategy and ensure that even the viable opportunities forward the CICO's goals. In the case of Select Health, we will only pursue opportunities that *help people get care, stay well and build healthy communities.*

NEW MARKET CONSIDERATIONS

A new market or new population caries specific viability concerns that may not be as dramatic in a previously managed market. Regardless, the vectors controlling market viability do not change. In short, the market rates need to cover the medical and administrative costs of the population while offering the contract owner a cost savings over the previous status quo. The CICO has a great deal of responsibility for building a competitive network and then supporting members, so that they receive the appropriate care at the right time.

When considering market entry, a CICO will need to consider the demographics and health status of the target population. The more that the CICO is able to understand the expected pent up demand and the needs of the membership, the better positioned the CICO is to identify and partner with key providers, community outreach and service organizations. Although Select Health has an impressive and successful care coordination and care management function, it takes time to shift the risk profile of a sick population and it takes time for the pent up demand to subside. Market rates that work with this understanding and reality are key in market viability.

IMPACT OF PROVIDER NETWORK

Working with Providers to establish competitive networks is a key metric of viability as well. Select Health takes pride in the relationships it creates with network providers and strives to always contract them at fair and competitive rates while also offering non-traditional contract elements like incentive payments for medical home participation and flexible administrative clauses around items such as pre-authorizations. However, an unfriendly provider community who is uninterested in serving the population in question or feels the compensation is unfair, can inhibit a CICO from meeting network access requirements. As discussed earlier in this document, Select Health has a number of strategies to mitigate this risk and engage providers in the network development process. However, an uninterested provider community can absolutely impact the viability of a CICO.

ENROLLMENT FIGURES

Enrollment is also a key factor in market viability, as the larger the market, the more a CICO is able to spread out administrative expenses. CICO market overhead is largely fixed by State and Federal regulations and the requirements placed on CICO support services and provider networks. These requirements are the same at the first CICO enrolled member as the millionth. As such, as the market grows, economies of scale offer the CICO a better chance of viability. Of course, unique requirements of a specific product can increase this administrative burden because unique requirements may not be able to be shared across multiple lines of business.

To ensure that a CICO is able to meet basic enrollment levels, and achieve benefits of economies-of-scale, Select Health recommends that SC DHHS limit the number of CICOs to a maximum of 3, understand that a minimum of 2 is required by CMS.

CICO ONGOING FINANCIAL VIABILITY

Select Health, and its parent organization, AmeriHealth Mercy Health Plan, is a financially stable company with access to significant capital meeting requirements of current Medicaid and Medicare plans. Select Health, and its parent organization, AmeriHealth Mercy Health Plan, practice responsible fiscal management and maintains more than adequate equity to protect it against the risk of insolvency.

Select Health, and its parent organization, AmeriHealth Mercy Health Plan, have adequate funds to finance all development and start-up costs related to participation in the Demonstration. As a current contractor under the First Choice Program, our expansion into the Demonstration will be incremental to existing business.

No condition is known to exist, by Select Health and its parent organization, AmeriHealth Mercy Health Plan, that might materially affect the viability or stability of the respective organizations.

IX. GENERAL

3. In the event your organization is selected to serve as a CICO, describe any specific roadblocks or challenges to the successful implementation of this Demonstration.

Select Health has been providing managed care services to South Carolina's most vulnerable population for over 16 years. During this time, we have built relationships with key health care systems, providers, community organizations and public health officials. We have also established a solid foundation upon which a successful demonstration can be built.

Our project management protocols dictate that roadblocks and challenges are proactively managed throughout a project. The following are scenarios that Select Health may encounter during the implementation of the program:

Table 3: Potential Roadblocks to Implementation

Roadblock/Challenge Identification	Roadblock/Challenge Impact
Rates are insufficient to support CICO operations	Inadequate funding would make the provision of services to the target population difficult.
Provider shortages	An inadequate provider infrastructure, either through geographic unavailability or an unwillingness to participate in the demonstration, could make service delivery more difficult and lead to delays in care and strain on the existing provider networks.
Insufficient time for network development efforts	Contract and rates terms should be provided promptly to allow CICOs to meet launch timetables. Payment requirements for RHCs, FQHCs, Home Health, Critical Access Hospitals and Health Professional Shortage Areas are not currently specified and limits contracting abilities.
Inability to share member data with all key parties	CICO internally developed data exchanges may not be able to share data with other CICOs
Inconsistent terms and definitions	If CICOs do not have clear data and quality definitions, CICOs will have difficulty in programming data systems and in sharing consistently defined member and provider data

Roadblock/Challenge Identification	Roadblock/Challenge Impact
Insufficient enrollment numbers to support membership concentration for PCMH	Lack of membership concentration could hinder a CICOs ability to offer provider payments for participation in PCMHs. This could inhibit providers willingness to participate in interdisciplinary care teams.

IX. GENERAL

4. Are there any additional significant issues not listed within this RFI that SC DHHS should consider? If so, please list and provide comments.

At this time, Select Health is of the opinion that SC DHHS raised all significant issues within the RFI. We are thankful for the opportunity to provide feedback to SC DHHS and look forward to future conversations.